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Vol. XIX

GRAND RAPIDS, MICHIGAN, FEBRUARY, 1920

No. 2

Original Articles

RADICALISM VERSUS SOUND JUDGMENT.

RAY R. REED, D.D.S.

BAY CITY, MICHIGAN.

The human mind is a collection of thoughts induced by daily contact and observations. It changes with the custom of the age. The psychological factors which enter into the changing of one's mind are interesting. Magnification, is the essential requirement necessary in "putting across" an idea or thought. This is portrayed in childhood, starting with the fairy tales and the goblins. In the process of primary education the mind is caused to become developed by problems in arithmetic and lessons in geography, the importance of which is magnified greatly in the child's mind in order to obtain the desired results. This method of development is not merely a method of childhood. We come in contact with it every day. The advertiser attracts us with huge signs soliciting his particular business. The larger the sign and the brighter the colors, the more apt are we to heed its message. The daily paper startles us with glaring headlines, in order that we will purchase and learn the truth, quite different from the original thought. It takes a radical in any line to cause the laity to make the proper deductions.

The criticism often heard, of men in special fields of medicine and dentistry, is that they are too radical. They lay too much claim to the importance of their field. This is true, to a certain extent, but let us give credit where credit is due.

In the development of medicine we find landmarks consisting of certain fads and fancies. They have all had their trial, and errors have been discovered. I speak of such fads as operation for gastropotosis, splenectomies for

pernicious anemia, electro-therapy for neuritis, emetin for pyorrhea, irrational dietary regulation, and numerous other treatments. At present we are in the midst of another period of our march toward "Perfection," namely, focal infection. Shall we accept or shall we reject it? That is the question surging in the minds of the profession to-day. Let us look at the subject from a sane point of view. Let us remember the mistakes of the past and decide whether or not we are merely in a stage of fanciful disillusionment? Let us not, however, think too strongly of the saying, "History repeats itself."

What is it that causes us to accept a method or a treatment? The answer is simple—success. Let us consider the subject of focal infection from the standpoint of its successes and failures. In this early period of its career we find that a majority of the cases have been of long standing and referred for dental observation, only after all other means have proved futile. This is quite similar to the treatment for appendicitis in the early days when the surgeon would delay operation until he elicited fluctuation.

I appeal to your sound judgment. Is it fair and just to ignore focal infection because neglected cases are not always successful? Any disease of long standing is more pernicious than a more recent infection. Even though cases of somewhat hopeless cure are referred to the dental profession, remarkable results have been obtained and symptoms greatly relieved. The common complaint of the chronic opponent to advanced ideas is that, "he has had all of his teeth out and yet he has showed no improvement." Absurd and unjust to say the least! When the streptococcus has established a lesion, in the gall bladder, heart valves, or joints, and has advanced to such a stage where it is "keeping a house all its own," it is ridiculous to expect complete relief by the mere destruction of the primary focus.

Successes on the other hand are seen constantly. Some of the firm believers in focal in-

fection refer their cases when the first symptoms are presented to them. At this stage particularly can we expect complete recovery. The results are convincing to anyone open to conviction, while the "chronic skeptics" lay the results to coincidence. Give credit where credit is due. If a case of arthritis is presented with distinct alveolar abscesses or infection, and the extraction of abscessed teeth and the cleaning up of the pyorrhea causes relief in the symptoms, what in the name of common sense did it, if the removal of the focus did not? It is poor policy to commit ourselves on certain things, that is true, but it is just as poor a policy to be backward and not admit the most obvious. It is true that radicalism is shown in this field, but use sound judgment based on clinical evidence primarily, and depend less on theory. Unless we do this, focal infection will drop into oblivion along with the fads mentioned in the beginning. It will meet its death and along with it will pass valuable advances in the development of science.

In conclusion, what we need is more and closer co-operation between the medical profession and the dental profession, such as exists in group practice. After all other treatments have failed, and you see permanency of disease established, do not expect the impossible to happen. The enthusiast must guard against promising a miracle. A middle ground must be struck whereby we are willing to lose some of our dignity by trusting in the judgment of others. Let us believe in what our eyes tell us is true. In so doing we not only benefit ourselves, but the all important individual, the patient.

SYPHILIS AT THE U. S. ARMY BASE HOSPITAL, CAMP GREENE, CHARLOTTE, N. C.

CLYDE F. ROSS, M.D.
RICHMOND, VIRGINIA.

AND

WALTER A. DE FOE, M.D.
DETROIT, MICHIGAN.

(Formerly Captains, M. C., U. S. Army).

In presenting this series of cases of syphilis admitted to the Genito-Urinary and Dermatological Service at the U. S. Army Base Hospital, Camp Greene, N. C., we realize very fully the many shortcomings of this presentation. From Nov. 1, 1917 to Dec. 1, 1918, there were cared for in the Hospital 458 patients, while there were 323 cases of latent syphilis sent in

from the Camp for treatment, making a total of 781 patients treated. To these 781 patients 2,797 doses of arsphenamine and 1,228 injections of mercury salicylate were administered, the average dose of arsphenamine being .547 gm.

It was the policy of the service at all times to keep in the hospital and treat all those patients having active manifestations of the disease until they were cured. For sometime it was the policy of the Camp Surgeon to have all antisypilitic treatment administered at the Base Hospital, but owing to the distance of the hospital from the Camp it was later decided to open a Venereal Infirmary in the Camp, at which all latent syphilitics and chronic gonorrheas were treated.

It was the intention of the Chief of the Service at the Base Hospital to give a course of six doses of arsphenamine and twelve injections of mercury, each administered at weekly intervals, then after a period of one month or six weeks without treatment, have a Wasserman Test made. If this plan could have been carried out we would have been able to report the result of the treatment; but under the later ruling of the Camp Surgeon, when the treatment was divided and the Chief of the Service at the Base Hospital had nothing to do with the patients after they left the hospital, it was impossible to follow the patients and the result of the treatment. On the other hand, the Chief of the Venereal Infirmary may have outlined a course of treatment different from the one outlined at the hospital.

The 323 cases of latent syphilis treated at the Base Hospital were sent in by the Regimental Surgeons with a Syphilitic Register showing that they had had treatment previously or else the serum reaction justified their beginning treatment.

Of the 458 cases cared for in the hospital, eleven were latent syphilitics who were in the hospital for other diseases, gave a history of syphilis and positive Wasserman and took treatment while there. Of the 447 cases of active syphilis, 189 were primary, 240 secondary, 14 tertiary and four cerebro-spinal. The few cases of tertiary syphilis differ greatly in proportion from what is seen in civil life due, of course, to the ages of the patients we were treating. There were not enough of these to draw any conclusion from, so they will not be discussed further. There were more than four cases of cerebro-spinal syphilis seen, but these were referred to the Neurologist on the Medical Service and if treated at all were treated there,

but as a rule these men were discharged without any treatment, unless it was some intravenous arsphenamine. There were also treated for the gastro-enterologist, a number of cases of syphilis of the stomach, the result of which we have no record.

During the administration of these 2,797 doses of arsphenamine, in which nearly all of the arsenical preparations furnished by the Government were used, we learned that there should be definite indications before the drug is used, for it cannot be said that its administration is without danger. In this series we had all the reactions, including one death, that one reads about in the current literature. As to the cause of these reactions, we don't think there is any one cause that will apply to 75 per cent. of the reactions. We are inclined to the belief that the greatest proportion is due to anaphylaxis, a number to the condition of the gastro-intestinal tract, and still a number to the mental condition of the patients. It was our pleasure to prepare the solution in the most approved fashion that could be obtained at that time. In the early life of the hospital, when we had none or few facilities, we'll admit we used at times sterile tap water, and we must confess that our reactions were no greater than when we used doubly distilled sterile water. The most frequent mistake we find in the preparation of the solution is that we are more liable to give a too acid solution than a too alkaline one.

PRIMARY SYPHILIS.

If syphilis is to be efficiently treated the treatment should be begun during the primary stage, and not only during the primary stage but before the Wasserman reaction has become positive. This is the ideal which we are coming more and more to obtain. In this series of 189 cases of primary syphilis cared for in the hospital, we have complete histories on 172. Of this 172 patients, 23 or 13½ per cent. were treated ideally; that is, diagnosis was made, confirmed by positive spirochete, and treatment begun before the Wasserman became positive. As the value of early diagnosis becomes more and more impressed on the profession and the laity, the more of these cases will be treated in this manner. We don't think anyone doubts that syphilis can be cured if treatment is begun before the Wasserman Reaction becomes positive, but many syphilographers doubt its being cured after this stage is reached.

The diagnosis of the primary stage of syphi-

lis is harder and gives more trouble than the other stages of syphilis. There are so many ulcers and lesions of the genitals with which syphilis can be confused, and the clinical features of the chancre are so very variable that the making of an early diagnosis is at times a task. There are lesions which an experienced man recognizes at once as syphilis, and the diagnosis which he does not hesitate to make and institute treatment even without the aid of the microscope, but there are others that so resemble the chancroid and other lesions of the genitals that he is compelled to rely solely on the laboratory for diagnosis.

It is our opinion that the profession is becoming more and more reliant upon the laboratory for the diagnosis of syphilis, with which we agree provided the laboratory diagnosis concurs with our clinical diagnosis; or, if we are undecided we are willing to let the laboratory help us decide; but we are inclined if there is a disagreement to take our clinical diagnosis in preference to the laboratory.

Volumes have been written on the clinical features of the chancre and chancres have been given all varieties of classifications, some of which sound very prosaic while others are inclined to be poetical, whereas in reality all of the classical features of the chancre have their many exceptions. Our experience has been that the getting of an accurate history in the army as to the period of incubation of primary syphilis is very unreliable. There are certain restrictions placed upon, and certain penalties imposed on, all those who contract venereal diseases in the service. Soon the more intelligent ones learn to concoct a story to suit their particular case so as to evade these impositions; and those not so intelligent, mostly negroes, can give you no definite history, so that we learned to pay very little attention to the period of incubation in forming an opinion as to whether the condition had the incubation period of a chancre or chancroid.

Induration is one of our main signs in making a diagnosis, but the exceptions to this sign are so numerous that it should be looked upon with suspicion. There was one class of cases that we recall in particular that were manifested by an indurated fissure of the margin of the prepuce. They had nearly every characteristic of the chancre, yet the spirochete remained absent and the Wasserman negative. These conditions existed in that class of men with long tight prepuces. Upon retraction of this prepuce, the margin would crack and every suc-

cessive retraction serves to increase the irritation and formation of connective tissue at this point and resultant induration. On the other hand, there is many a chancre which in the beginning, and this is the time the spirochetes are abundant and treatment should be instituted, that shows no signs of induration, just a red superficial ulcer as pliable as the skin or mucous membrane on any part of the body. In this series of cases 9 per cent. proved to be multiple, while in our 195 cases of chancroids 34 per cent. were single. So the old rule, chancres are single and chancroids are multiple, has its exceptions. Our percentage of mutiple chancres is a good deal lower than the average, which was due to the fact that one of two things, or both, had to exist before we would diagnose multiple chancres; one being the clinical features of any and every ulcer leaving no doubt in our mind as to its being a chancre, and the other the presence of the spirochete pallida. The Wasserman would not help us any in this case, for the Wasserman could become as positive from one chancre as from a number.

The diagnosis chancroid on our service was made by exclusion, as we and the laboratory men with whom we have been associated believe it possible only in a very small percentage to make the diagnosis of chancroid by finding the bacillus of Ducrey. So we have diagnosed and classified all conditions chancroids which had the clinical features of chancroids and could not be classified as syphilis or other known lesions. Primary syphilis was complicated with chancroids in 13 per cent. of this series.

A suppurating inguinal adenitis in conjunction with an ulcer on the genitals does not necessarily mean that the ulcer is not luetic, for one knows that even in the Bubo complicating the chancroid that the cause of the suppuration is pyogenic infection and very seldom due to the bacillus of Ducrey. If so, why should not that same pyogenic organism enter the inguinal gland by way of the chancre as well as the chancroid and produce a suppurating adenitis.

Undoubtedly the most valuable indication of the presence of any syphilitic lesion is the spirochete pallida. There is always in our mind an error of doubt in the Wasserman reaction because of the many errors that might creep into the making of this reaction, and also that there might be other diseases with which the patient is suffering that would cause an erroneous conclusion, but the finding of the spirochete pallida on the dark field by one who

knows the pallida from the other forms of the spirochete, leaves no room for doubt. It is our impression that the dark field method is the most reliable for diagnosing the spirochete pallida from the other species of the spirochete, for here we see the spirochete in motion, and the motility is one of the most important, if not the most important, characteristic of the spirochete pallida. A negative finding means that very likely the lesion has been treated by antiseptics; that the lesion has been present a long time and instead of the spirochetes growing on the surface they have penetrated into the deeper layer of the chancre, or else that the lesion is not syphilitic. In case the lesion has been treated by antiseptics, it should be dressed in normal saline solution for 48 to 72 hours before we can hope to find the spirochete. In case the lesion is an old one, serum obtained from the deep layers of the ulcer should be examined. We have never been very successful in obtaining the spirochete from the inguinal glands by puncture. Very often the question will arise as to how many dark field examinations should be made, and the answer is an indefinite number or until the organisms are found. At times they will be located on the first examination, at others, not until the twelfth or the twentieth. The positive Wasserman is the last sign to appear in primary syphilis. This will become positive at varying intervals. We have gotten positive Wassermans three days after the appearance of the lesions, taking the patient's word for the time of appearance of the chancre.

We would hardly like to say an ulcer was positively not syphilitic, unless there were no secondaries and the Wasserman was not positive for a period of three months. The Wasserman should be performed at least once every week, and better twice. It was always our routine to confirm one positive Wasserman by another in case our clinical symptoms were very doubtful. We should never lose sight of the fact when we get a positive Wasserman that the patient may have latent syphilis and that the symptoms are not those of syphilis but of some other disease which exists at the same time as the latent syphilis. We have been forced on a number of occasions to make a diagnosis of chancroids and latent syphilis when the history was one of having had syphilis before and very likely having had treatment, but the clinical signs were those of chancroids and the examination for spirochetes was not positive.

The average length of time spent in the hospital by these primary syphilitics, which com-

prised the time consumed in making diagnosis and taking treatment until all active lesions were healed, was 22.4 days; the number of doses of arsphenamine 3, and injections of mercury, 2. The uncomplicated cases stayed only 20 days in the hospital, while those complicated with chaneroids averaged 37.3 days.

The locations of the lesions were in 67 per cent. on the prepuce, 14 per cent. in the coronal sulcus, 6 per cent. on the glans penis, 5 per cent. on the shaft of the penis, 4 per cent. on the frenum of the prepuce, 2 per cent. in the meatus urinarius, and 2 per cent. on the tongue. Of the latter two were musicians and evidently contracted the disease by letting infected persons use their instruments.

It has been the opinion of one of us (Ross) gained from civil life, that the negro was more easily cured of syphilis than the white man. His Wasserman will become negative sooner, stay negative longer on less treatment than the white man's. This impression was carried in the army, and we find that 46 cases of primary syphilis, in the white man, spent an average of 28.75 days in the hospital and took 4.2 doses of arsphenamine, whereas the 126 cases of primary syphilis, in the negro, stayed in the hospital on the average of 21.3 days and took 2.44 doses of arsphenamine.

SECONDARY SYPHILIS.

The diagnosis of secondary syphilis was made from the history, which was of a great deal more value than in the primary stage because generally speaking no penalties could be imposed, the clinical manifestations, and the Wasserman reaction. The Wasserman reaction is, of course, of more value in this stage than in any other stage of syphilis, but we always considered it one manifestation of syphilis only, and still depended upon our clinical signs in helping arrive at a diagnosis. We might also say that in a number of cases, the darkfield examination was availed of for immediate confirmation of the clinical diagnosis, which was later confirmed by the Wasserman reaction. Caution should always be exercised in the use of the darkfield for the examinations of lesions of the mouth, because the mouth is the natural habitat of other species of spirochete. The Wasserman was positive in 96 per cent. of our secondary syphilitics, the other 4 per cent. were given treatment upon a diagnosis made from history and clinical manifestations, although the reaction was negative.

In the 240 cases of secondary syphilis the

mucous patch comprised 50½ per cent. of the clinical manifestations, the syphilides 19½ per cent., adenopathy 26 per cent., the condylomata 21½ per cent., and alopecia 1½ per cent. The distribution of these lesions might be of interest, 27 per cent. of the mucous patches were on the prepuce, 15 per cent. on the glans penis, 12 per cent. on the tonsils, 11 per cent. on the lips, 9 per cent. on the tongue, 8 per cent. on the cheeks, 4 per cent. on the gingiva, 4 per cent. on the scrotum, 3 per cent. in the pharynx, 3½ per cent. on the shaft of the penis, 2 per cent. on the fauces, and 1½ per cent. on the uvula.

Fifty-five per cent. of the syphilides were macular, 34 per cent. were papular, 6 per cent. were pustular, 3 per cent. were annular or circinate on the face, and 2 per cent. were erythematous.

Of the condylomata 44 per cent. were around the anus, 33 per cent. on the prepuce, 12 per cent. in the coronal sulcus, and 11 per cent. on the scrotum.

Of the adenopathies, 71 per cent. were general while in 29 per cent. were the inguinals alone involved.

The average length of time spent in the hospital by these 240 cases of secondary syphilis, which included time occupied in arriving at diagnosis and administering treatment until all active lesions had healed was 15.96 days, the average number of doses of arsphenamine was 2.5 and injections of mercury 2. The secondary lesions were more superficial and consequently healed more readily than the lesions of primary syphilis. Again the diagnosis was more easily made, and not so much time consumed in this manner.

SUMMARY.

No one sign, either laboratory or clinical, should be depended upon for the diagnosis of syphilis, but the laboratory and clinical signs should be closely examined and conclusions reached by a study of all the information available, never forgetting that the diagnosis of syphilis was made long before the advent of the Wasserman.

The ideal time to begin treatment in syphilis is before the appearance of the positive Wasserman during the primary stage. This should be our aim in our future relations to the treatment of this disease.

Nine per cent. of our chancres were multiple while thirteen per cent. were of the mixed variety; that is, both chancres and chaneroids were present.

Primary syphilis can be diagnosed and all active lesions healed in twenty days, with an average administration of three doses of arsphenamine and two injections of mercury.

Secondary syphilis can be diagnosed and all active lesions healed in sixteen days, and with two and a half doses of arsphenamine and two injections of mercury.

The administration of arsphenamine is not without danger and it should not be administered except when indicated, which indication is the existence of syphilis, active or latent, and then only under the best conditions possible, and by one who can meet any emergency that may arise.

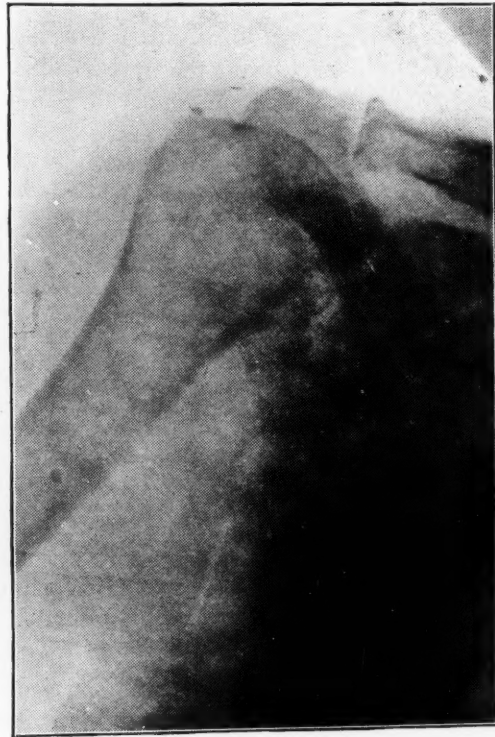
The negro is more amenable to treatment than the white man, as shown by the comparative length of time spent in the hospital by the two classes of patients.

501 Professional Building, Richmond, Va.
80 Griswold Street, Detroit, Mich.

SURGERY OF THE SUPRASPINATUS MUSCLE.

A. S. KITCHEN, M.D.
ESCANABA, MICH.

For some two or three years past I have come to regard the supraspinatus muscle with



CASE II.

considerable respect. Of some one hundred injuries to the shoulder where X-ray plates have been used for diagnosis, I have found the insertion of this muscle torn out in about ten cases,



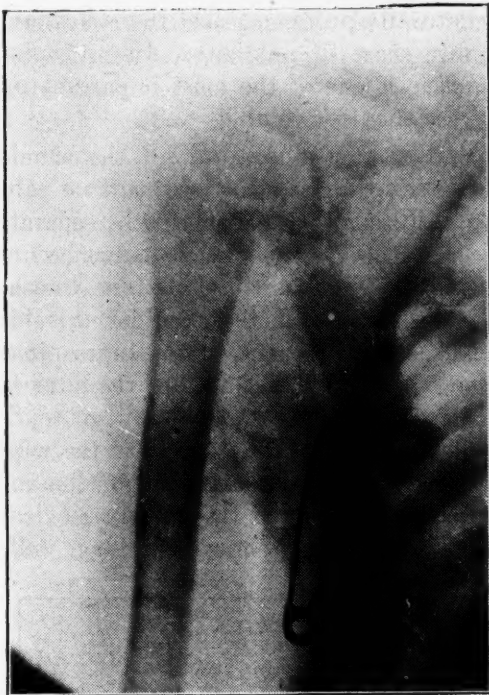
CASE I. Separation of supraspinatus insertion.



CASE III.

as indicated by the separation of the topmost portion of the greater tuberosity of the humerus.

My attention to this injury was first drawn in the case of a mechanic, who while intoxicated,



CASE IV.



CASE V. Dislocation and separation of supraspinatus insertion.



CASE VI.



CASE VII.

and being in some restraint, had torn out the insertion of this muscle by trying to shake off his well intentioned supporter by an outward and upward thrust of his elbow. He had suffered so painfully from this injury for two

months that he finally decided on an X-ray. He had treated with a physician at first, and later had taken, from an osteopath, severe massage treatments with vigorous manipulation of the shoulder, with naturally very painful and

location showed this complication to which only a casual reference was made.

Now when one considers the painful and prolonged disability that results from this minor injury and the frequent neglect and often pernicious treatment of these cases, one must naturally protest against their not having their fair share of publicity. In my opinion this muscle is one of the most important muscles of the shoulder joint.

In my cases of dislocation of the shoulder (which according to Keen constitute about 50 per cent. of all dislocations), the separation of the insertion of the supraspinatus occurred in one-half of the cases. When one comes to study the anatomy of the shoulder this looks reasonable enough because if the supraspinatus hung on hard enough the head of the humerus could hardly slip down enough to get out of the glenoid cavity. The tendon of the supraspinatus hooking under the horn of the spine of the scapula and under the acromio-clavicular ligament runs over a sort of steadying, pulley-



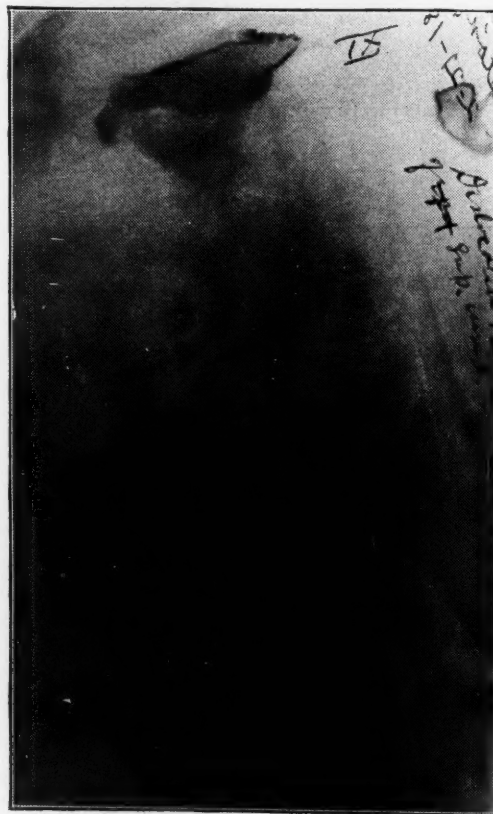
CASE VIII. Fracture and separation of epiphysis.

disappointing results. As he was an expert plumber he was quite incapacitated and consequently was losing the proverbial plumber's fortune during his disability.

The outward appearance of the shoulder was negative and manipulation showed nothing abnormal in the way of crepitus, but the pain was very severe in elevating the elbow to the horizontal. X-ray showed the separation of the attachment of the supraspinatus to the greater tuberosity.

The second case, of some months standing also, came to me within a week or two and resulted from, as she described, "her daughter snatching a towel from her hand from behind," while her arm and forearm hung perpendicular along the body.

A third case happened within six months and by this time I came to the conclusion that these cases were quite more frequent than indicated in the textbooks. On consultation with Bryant & Buck I found four lines of information; Keen has one line and a half. Strange to say the only X-ray plates illustrated on shoulder dis-



CASE IX. Dislocation and separation of supraspinatus insertion.

resisting rotation forward or backward, and is inserted into the topmost facet of the greater tuberosity of the humerus, practically the pivotal point in this most important bone in the most important joint of the human body.

Not only this but it crosses beside the long-head of the biceps as it comes out of the synovial lined sheath in the bicipital groove on its way to its insertion in the upper edge of the glenoid cavity. These two tendons pass each other very closely and are very intimately connected with the capsule of the joint and play a decidedly intricate function in the finer and more delicate movements, such as in swimming and in baseball.

I think most of the pain in connection with separation of the insertion of the supraspinatus is due to the irritation of the synovial sheath of the biceps tendon and not due to impinging the fragment against the acromio-clavicular ligament, and consequently persistent massage and even the light use of the arm in ordinary duties, tend to keep up a painful tenosynovitis and prolong disability.

It would be interesting to show plates and go further into the anatomy of these cases but time will not allow and anyone can easily get a collection of cases of his own if he will resort to the X-ray as a routine in all injuries to the shoulder.

A REFINED TECHNIC IN INTESTINAL DRAINAGE (ENTEROTOMY) FOR INTESTINAL OBSTRUCTION.

HENRY J. VANDEN BERG, M.D.
GRAND RAPIDS, MICH.

Intestinal obstruction has always been regarded as a very serious surgical condition because it carries with it a high mortality; but less so (according to Traves 50 per cent.) since it became a custom to evacuate the intestinal contents.

Simply relieving the obstruction, and allowing the highly infectious and toxic fluid that has accumulated to pass down into the healthy and thirsty distal intestine, is too often overwhelming to the patient.

The exact nature and origin of the toxins developed is, I believe, not yet definitely known; but whatever it may be, the value of drainage as a life saving measure is now regarded as a fundamental principle in surgery that must be observed but is not always carried out.

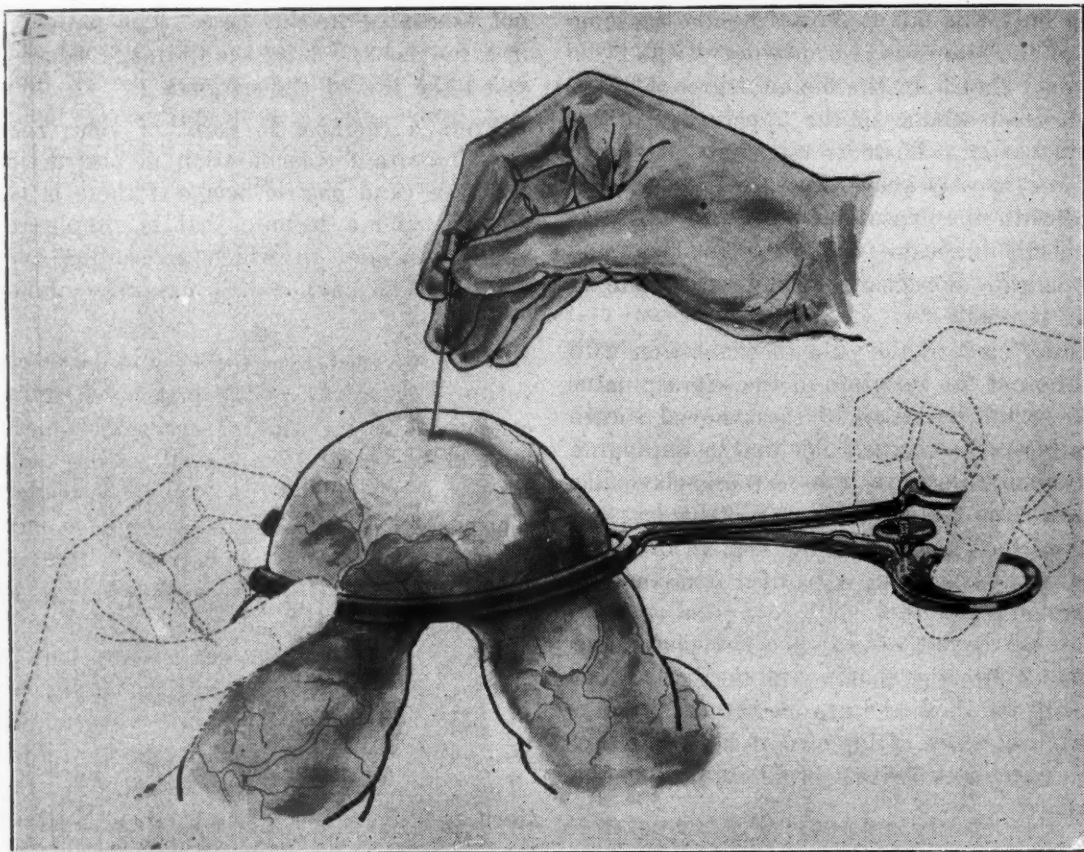
A few years ago I saw a case of obstruction of only eight hours standing involving a loop of small intestine that was caught under a post-inflammatory band. The operation was most simple, only the band being divided to release the obstructed knuckle of gut. The bowel was

not evacuated in this case. The patient died in a few hours. I believe drainage would have saved the life of the patient.

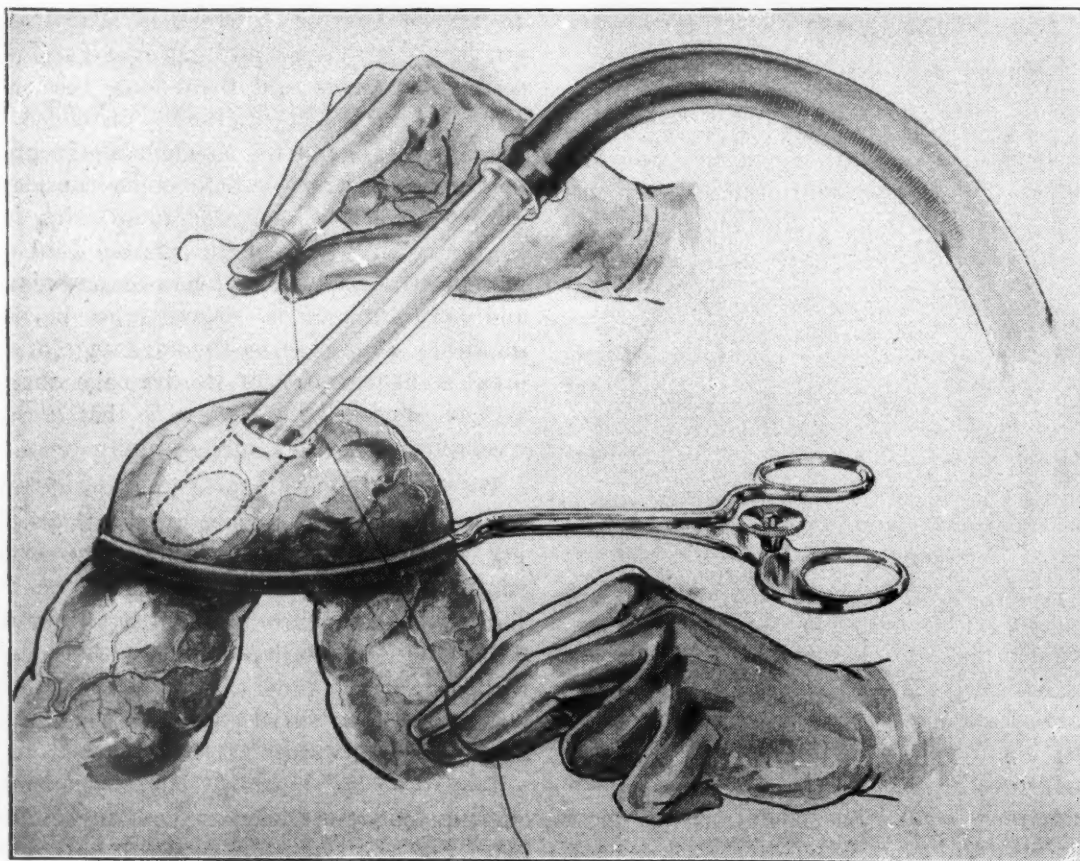
From a therapeutic point of view, then, a very important consideration in obstruction is drainage (and gastric lavage if there is regurgitation), and a technic that is simple in its application and in which all soiling is prevented. The methods are naturally numerous and varied.

We have used the trochar and purse-string suture, and so far as the matter of soiling is concerned this is a very satisfactory method; but on account of the small calibre of the trochar several punctures have to be made and then the emptying is not complete enough. Moynihan's technic is today, I believe, most generally used. He devised a glass tube about 8 inches in length and about $\frac{3}{8}$ of an inch in diameter, which is introduced into the lumen of the gut thru a longitudinal incision about an inch in length. The bowel is then pushed gently along the tube, as illustrated in Fig. B. "The tube and gut are then seized in a wrap of sterile gauze and held firmly by an assistant so that no leakage occurs by the side of the tube." We used his tube and technic but in our experience it was not possible, in all cases at least, to prevent soiling. "Holding the tube and gut firmly with a wrap of gauze and so prevent soiling" is easier said than done, because the gut is usually quite markedly distended with fluid and gas, and the moment an opening is made the gas which is held under considerable tension tends to escape, and in so doing is apt to carry with it some of the infected fluid. The patient is already carrying a hazardous load and peritonitis of no degree must be superimposed. Prompted by the advantage of Moynihan's tube because of its drainage qualities, we have modified his technic so that it can be accomplished without any soiling.

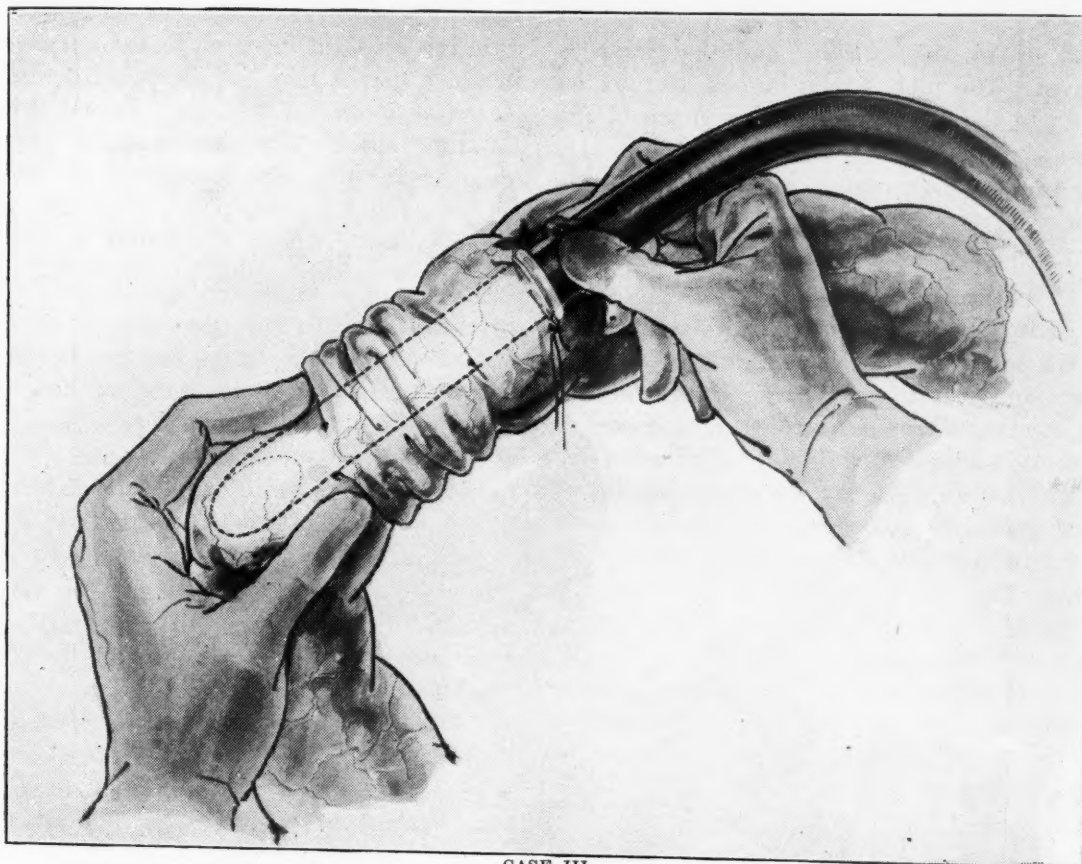
We first of all collapse a knuckle of gut by letting out the gas thru a hypodermic needle, Fig. I., and then with the fingers strip down on the gut to empty it of its fluid contents. This latter procedure is less important than the former. The collapsed loop is then grasped with a rubber tubing covered forceps to prevent any rushing out of any of the gut contents. A purse-string suture is then stitched in the wall opposite the mesentery, and a longitudinal opening made just large enough to admit the tube, Fig. II. As soon as the tube has been introduced beyond the tip the purse-string is



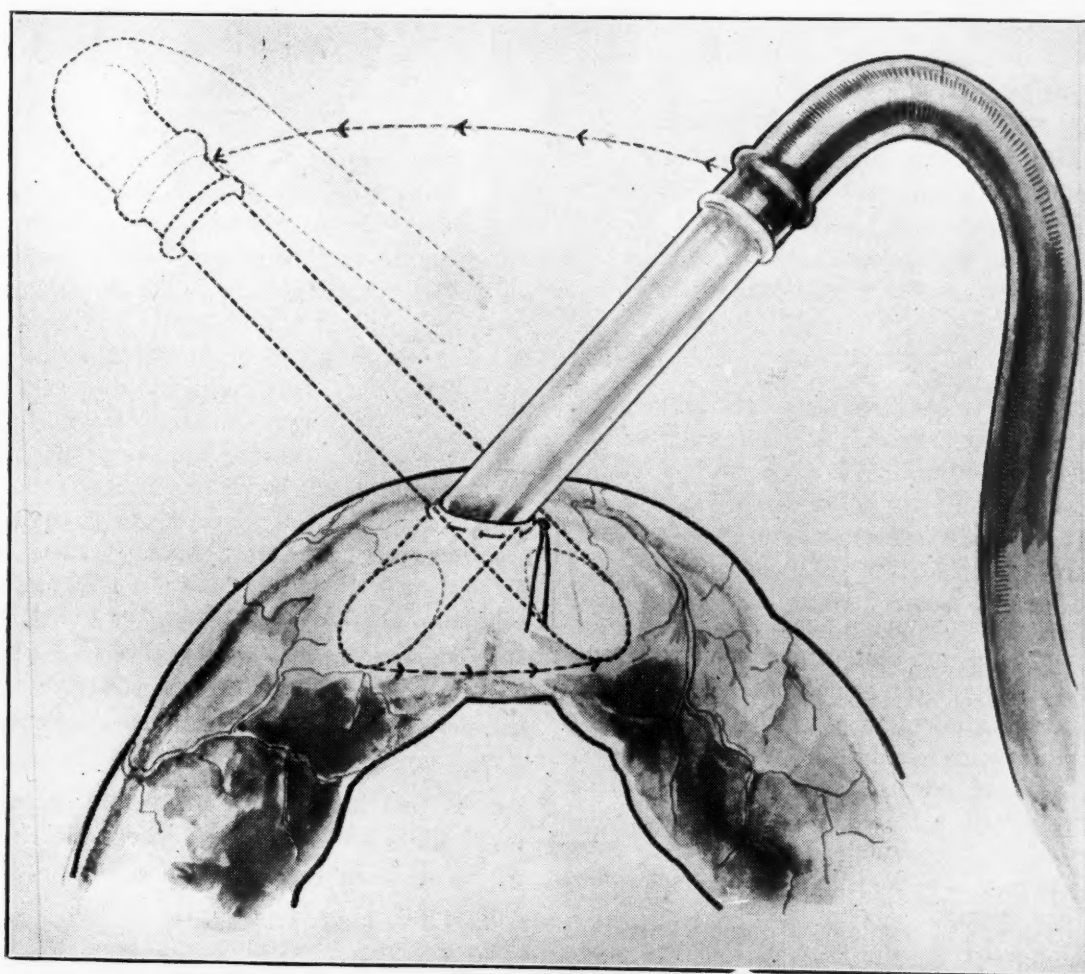
CASE I.



CASE II.



CASE III.



CASE IV.

pulled up by the assistant and the clamp is removed. The tube is then pushed up into the gut up to the flange, and then as much of the gut as possible is pushed onto the tube, Fig. III. This procedure is repeated in the opposite directions, as illustrated in Fig. IV. In acute cases several feet of intestine can be negotiated in this way: in chronic obstruction with hyper-

dure the assistant holds on to the purse-string, in order that it may not loosen with resulting escape of intestinal contents. In withdrawing the tube special attention must be given to lowering the drainage mechanism so that the tip forms the highest point while the purse-string is being drawn down over it. Fig. V. The object of this is that any fluid left in the



CASE V.

trophied walls obviously much less. If there is still unloaded gut that cannot be pushed onto the tube, the gut can sometimes be held up and its contents allowed to run out. In doing this, care must be exercised not to pull on the mesentery. We are now using a tube nine (9) inches in length with a half ($\frac{1}{2}$) inch lumen, which has a distinct advantage in negotiating more gut. It now is seldom necessary to make more than one opening.

Throughout the drainage part of the proce-

ture the assistant holds on to the purse-string, in order that it may not loosen with resulting escape of intestinal contents. In withdrawing the tube special attention must be given to lowering the drainage mechanism so that the tip forms the highest point while the purse-string is being drawn down over it. Fig. V. The object of this is that any fluid left in the

tube may gravitate away from the bowel. The free edges are carefully wiped with a sponge and alcohol applied. Then it is reinforced with a running suture in the transverse direction. The gut wall can be so thin from overdistention that it is almost technically impossible to do either an enterotomy or enterostomy, but where it is desirable and possible to do an enterotomy I recommend the technic as here described and illustrated.

ETIOLOGY OF ORGANIC HEART DISEASE.

M. A. MORTENSEN, M.D.

The progress of medicine has been one of evolution out of ages of tradition. In medicine, as in other sciences, tradition wields an almost everlasting influence. Superstitious beliefs of bygone ages still cling to the laity, and may we not ask ourselves if we are entirely free? Are we not inclined to believe without reason, and accept statements coming from high authority without sufficient proof? This applies to the history of heart diseases as much as to that of any branch of medicine.

Since the early days of medicine, heart disease was an acknowledged fact, but in its evolution Harvey in 1619 must be given the credit of putting the subject on a stable basis when he announced the discovery of the circulation. He made physiology the foundation on which further observation rested. Galen had referred to heart disease, basing it on his studies of anatomy, noting pericardial exudates and polyps as deviations from the normal. In the first half of the eighteenth century, Valsalva, Vieussens, Lancisi, Senac and Morgagni deserve special mention for their studies in anatomy and diseases of the heart.

More than a hundred years ago, Corvisart defined organic lesions as "every species of alteration which occurred in the texture of the solid parts, whose determinate concurrence and arrangement are requisite to form an organ and to establish its action and duration." Not many of us would attempt to add to this definition. He also called attention to the fact that "The muscular substance is what most essentially constitutes the central organ of circulation, acting the principal part in its organization, since to the contractility of the muscular fibres the motions are entirely indebted, which give impulse to the fluid which the heart causes to circulate."

These are fundamental facts that every one of us must bear in mind in our consideration of every case suffering with heart disease, and our success will depend on our ability to recognize the damage done to the heart as a tissue, and the resulting impairment of function.

The greatest work that we, as medical men, can perform for the human family is that of prevention of disease, and if you look at the mortality cases for organic diseases of the heart we cannot help but see the great necessity of

concerted effort in this direction. To do our best here, it is essential that we thoroughly understand the etiology of these diseases. We have all witnessed satisfactory decline in mortality rates in tuberculosis, typhoid fever, diarrhoeal diseases of infancy, all because the etiological factors were clearly understood. The next step was the general education of the public, teaching them the cause and what they must do to inhibit the spread of the disease. Tuberculosis clinics and antituberculosis campaigns have been carried on everywhere with good results and still better results to come. Boards of Health everywhere warn people about the dangers of typhoid from drinking water, and proper sanitary regulations are carried out everywhere to prevent water and milk contamination, with the best of results. Along this same line, should we not consider the organizing of cardiac clinics in our cities for a two-fold purpose, viz; to teach those already afflicted what to do to postpone as long as possible cardiac decompensation, and at the same time remove possible foci of infection that may continue a menace to the myocardium, and secondly, to arouse an interest by the laity as well as the profession in the types of infections that are a menace to the heart.

In New York City, cardiac clinics have been established for the prevention of heart disease and the proper education of those already afflicted. The results justify the continuation of such clinics and with the co-operation of the general practitioner the benefits will show a decline of the mortality rate from organic heart disease.

MORTALITY.

Mortality statistics for 1915 show a steady decline since 1900 in the occurrence of tuberculosis and typhoid fever in the registration area of the United States, but this has not been the case with organic heart diseases. From Mortality Statistics for 1915, I quote "Organic diseases of the heart caused more deaths (99,053) in the registration area in 1915 than any other single cause, even exceeding the number due to all forms of tuberculosis (98,194). The deaths charged to organic heart diseases in 1914 numbered 93,588. The rate from this cause in 1915 was 147.1 per hundred thousand population, as against 141.8 in the proceeding years and 111.2 in 1900. The increase in the mortality from organic disease since 1900 is the more noteworthy in view of the decline in the rates from tuberculosis of the lungs and

pneumonia (all forms) and the smaller increase in that from Bright's disease and nephritis."

Is it not possible that we are too optimistic in our conclusions in many cases presenting abnormal heart action. We have all observed cases with apparent evidence of organic lesions that have experienced no subjective cardiac discomfort over a period of many years, and because of these observations, we are prone to think certain evidences of lesions have little or no influence on prognosis. According to Fisk, insurance statistics in supposedly types of so-called valvular murmurs show an extra mortality ranging from 50 to 100 per cent. Even the so-called functional murmurs, or murmurs not classified as characteristic of valvular lesions have an extra mortality of 50 per cent. In the experience of forty-three Life Insurance Companies, a persistently irregular pulse showed an extra mortality of 50 per cent. in lives accepted on standard policies. It is perhaps true that statistics are not always to be accepted as proof, but, as a rule, they may be relied upon to show the trend, and here the margin is so large that they must be accepted as evidence showing that some of the so called harmless cardiac symptoms undoubtedly influence the cardiac efficiency, and through it, the length of life.

These facts emphasize the great necessity of using the utmost care in judging the efficiency of the myocardium, the keystone to the circulation, and on our skill will depend our success in the prevention of untimely deaths in cases showing evidence of abnormal heart action.

ETIOLOGY.

Organic heart lesions are mostly acquired, a few being of congenital origin. The acquired lesions involve the pericardium, endocardium and myocardium, and their importance depends entirely on the extent of their influence on the efficiency of the heart muscle. The evolution of our knowledge of heart disease shows very clearly that the etiological factor of first importance is some infection. Ever since organic lesions have been recognized, acute inflammatory rheumatism has been associated with heart disease by all prominent writers, with the endocardium the point of attack. Bouillaud was the first to use the term endocardium, and has the credit of first associating disease of the endocardium, including the valves, with acute inflammatory rheumatism, and emphasizing the frequency of endocarditis in poorly managed cases of rheumatic fever. He also noted that all signs of rheumatic disease might disappear

but evidence of the endocarditis persisted. Corvisart, Bamburgh, Latham and Stokes all confirmed these observations and also recognized rheumatic fever as an etiological factor in pericarditis and myocarditis. Austin Flint refers to a series of 474 cases of acute inflammatory rheumatism, analyzed by Fuller, and found endocarditis existed in 214, a ratio of 1 to 2.25. Early writers also refer to exposure to cold, trauma, severe physical exertion, tuberculosis, pneumonia, pleurisy, pyaemia, puerperal fever, scarlet fever, measles, diphtheria, caries of ribs, bronchial abscess or ulcer, perforating ulcers or carcinoma of esophagus or stomach, hepatic or splenic abscesses, as possible causes of organic heart disease.

Association of throat inflammation with organic heart disease was not definitely referred to as an etiological factor until towards the latter part of the last century. Caton in 1900 reports eighty-six cases of rheumatic fever, in which he notes exposure to wet and cold as the most important fore-runner of rheumatic fever and heart disease, mentioning it in thirty-two cases, while he refers to tonsillitis or a severe cold in six cases and chorea in five cases. In recent years avalanche after avalanche of evidence has been that nearly all cases of valvular heart disease involving the mitral valves, and particularly stenosis give a clear history of throat infections in form of tonsillitis or quinsy, some followed by rheumatic fever. In a series of 400 mitral lesions a history of throat infections, inflammatory rheumatism or other streptococcic infections were given in 305 cases.

The acute throat infection, rheumatic fever, scarlet fever, diphtheria, typhoid fever, pneumonia and pleurisy and other septic infections result in myocarditis as well as endocarditis. Christian of Boston has recently reported sixteen cases of acute pericarditis following rheumatic fever in which five and possibly a sixth developed a heart block, proving an involvement of the conducting system of the myocardium. Postmortems have frequently revealed more or less extensive myocarditis with or without endocarditis following acute infections, this being particularly true of diphtheria, typhoid fever and pneumonia.

If we could devise some means or method by which we could eradicate or materially decrease the frequency of throat infections in the young, we would do much towards decreasing the frequency of endocarditis and resulting valvular diseases. I think we are prone to consider

throat infections as a purely local disease, forgetting the possibilities of an endocarditis. Any child with a predisposition to repeated tonsillitis should be seriously studied and tonsillectomy urged if tonsillar crypts become foci of infection.

Typical myocarditis is most common in the latter decades of life, being particularly common in those suffering with old valvular lesions of rather severe grade, with or without arteriosclerosis. The sclerosis is especially productive of myocarditis where the aorta is extensively involved, including the coronaries and interfering with nutrition of the myocardium. The early detection of the hypertension is of great value in these cases, because if a cause can be found, it is more than likely it has a direct influence on the myocardium. In some, an angina symptom complex is the first suspicion of heart disease, and this may occur with or without hypertension. If the arteries are like pipe-stems, or beaded, then we have a right to suppose that we have a coronary sclerosis, but if not, and blood pressure is not increased, then we must look for causes liable to produce a localized arteritis or coronary spasm. Here a focal infection with resulting toxine is to be expected, and the tonsils with infected crypts, apical abscesses of teeth, sinusitis, are to be suspected, or possibly chronic appendicitis, diseased gallbladder or prostate. In any case of this nature, a most diligent search must be made for any and all possible sources of infection. Within the last year, I have had a number of cases where the elimination of chronic foci of infection in teeth, tonsils or sinuses have resulted in wonderful relief from symptoms of myocardial disease. Two cases with all the classical subjective symptoms of angina pectoris were entirely relieved by the removal of infected teeth.

Obesity with its resulting fatty infiltration is an important cause of myocardial insufficiency, and in some cases, it may be a factor in causing symptoms of angina. A case of this kind came under my care unable to walk a block without having to stop and rest because of precordial pain radiating into the neck and arm. With careful reduction of weight of about twenty pounds and simple laxative diet, much greater freedom in walking was experienced, and now, about four years later, with a total reduction of forty pounds is able to walk twenty miles a day without the least cardiac distress. These experiences emphasize the importance of carefully studying every case of myocarditis

with or without angina, and not put them all in the down and out class, proscribing all form of exercise.

In 1857 Banberger referred to syphilis as a cause of myocarditis. In spite of this, it is only in recent years that we have generally classed it as an etiological factor, and Dr. Warthin deserves much credit for his researches, enabling him to present the evidence in such a vivid way as he has done the last few years. He has shown that syphilis is a very common infection in the heart muscle. The symptoms of early myocardial infection are very vague, and is it not possible that in many of the obscure cases of heart trouble that we are inclined to consider functional, such as tachycardia, premature beats, and so-called irritable hearts, we have a syphilitic infection, possibly of congenital origin, or perhaps a streptococcic infection the history of which cannot be obtained.

It is my experience that a possible cause for these obscure symptoms may be found if we take sufficient time to get a careful history of the patient's various infections.

Renal disease, particularly the interstitial type and goitre with hyperthyroidism have a profound effect on the myocardium, resulting in extreme degrees of hypertrophy which sooner or later leads to varying degrees of degeneration, often with fatal consequences. Just how these diseases produce such profound effect on the myocardium is still a disputed question, but it is reasonable to suppose that there are two factors, namely, a toxemia, concomitant with the diseases, that affects the heart and circulation in general and an increase in the amount of work demanded of the myocardium.

Physical overexertion results in changes in both valves and myocardium. Sudden and extreme exertion may result in a rupture of valve leaflets or an acute dilatation, while exertion more prolonged in nature results in marked hypertrophy which later in life is apt to undergo various forms of degeneration.

In closing, I would emphasize the importance of a careful investigation of the history of infections as well as the study of the function of the myocardium as evidenced by the daily experience of the patient. This applies to children as well as adults. We have been too prone to depend on the physical findings alone in judging cardiac conditions, and when we realize that all possible factors must be studied, we will better understand the management of organic heart lesions.

WHY THE PAIN OF PEPTIC ULCER IS
BEST ACCOUNTED FOR BY THE
CORROSION OF GASTRIC JUICE
RATHER THAN BY HUNGER
CONTRACTIONS AND
HYPER-TONUS.

C. EMERSON VREELAND, A. B., M. D.
DETROIT, MICH.

During the last four years physiologists, throughout the country, stimulated by the work of Pawlaw and Cannon, have been experimenting constantly with problems of gastric motility. By means of rubber balloons and tubes placed in the stomach and attached to recording drums, the number and pressure of gastric contractions have been recorded very accurately during the hunger phase and the digestive phase. Carlson and Hardt have done the most work. Certain clinicians, viz., Smithies and Hamburger, have added to the pathological and therapeutic data on the subject.

Stated briefly, the results of these recent experiments have created a greater clamor in favor of overthrowing the old theory of ulcer pain by assuming that the corrosive peptic juice (hydrochloric acid and pepsin) does not eat into the open ulcer causing pain and accompanying spastic contraction. They say the pain is due to deep contractions of the stomach wall itself and to a strong hyper-tonus. They advise correction of this by giving belladonnae, carbohydrates and warm fluids in small quantities. They give us nothing new when they state that carbohydrate foods leave the stomach more quickly than proteids and fats; that the contraction waves influenced by carbohydrate foods are much weaker and less tonic than with other foods; that because carbohydrate foods empty more quickly, the stomach obtains rest more quickly; that acids, too, pour out in lesser quantity; and that the peptic ferment is of lesser concentration. These same adherents of the carbohydrate diet, however, forget that the normal human body requires from 75 to 125 grams of protein foods daily to maintain its basal metabolism. In examining more carefully the carbohydrate diets which they have standardized for ulcer treatment and which they have based on the above hyper-tonus theory, you will find that protein foods are added rapidly after the third and fourth weeks of ulcer management. Certainly the ulcers are not cured in this brief time, and if not, this type of management is illogical and open to grave criticism. Any medical management

which is not rigidly carried out for a period of eight to twelve months may fail because most chronic ulcers will not heal sooner than that time. Because the symptoms disappear it cannot be said that the ulcer is cured. Usually the crater of the ulcer has only been filled in with soft granulation tissue which may be broken down in a few weeks or months after returning to a normal diet. This type of case is called a re-currence and is charged to the internist as a medical failure.

Any good posterior gastric-enterostomy is better than these short inaccurate medical managements because it is permanent in its effect on the ulcer, and it allows few returns of symptoms whether or not the ulcer heals in two months or two years after the operation.

To believe in the corrosion theory as regards the pain and delayed healing of ulcer, it is not necessary to believe that peptic juice corrosion causes the ulcer. It means only that once an ulcer is present the corrosion causes pain and spasm and prevents healing, such as would occur if the ulcer were situated elsewhere in the body and continually irritated. Peptic ulcers are caused by devitalization of a localized area in the gastric mucosa, which may be toxic, bacteriologic, triphic traumatic or thermic—and only after this local accident occurs does corrosion take place, with its consequent pain.

The Leube, Ziemssen, Lenhartz and Einhorn treatments for ulcer are all based on the corrosion theory, *partially* controlling the corrosion. The gastro-enterostomy operation is also based on this theory, and it matters not whether you argue the success of this operation as due to the drainage of corrosive juices and stagnated-foods, or to the neutralizing effect of bile, pancreatic juice, intestinal juice, or stomach mucus.

With these preliminary remarks in mind, I wish to state briefly my reasons for believing in the corrosion theory.

IN SUPPORT OF THE CORROSION THEORY VS.
HYPER-TONUS.

Because pepsin in presence of a free acid will dissolve proteins, such as fibrin, beef-steak and coagulated egg white. So why will it not digest a devitalized area of the stomach wall itself? (Pepsin is inert in a neutral or alkaline media).

Because in the dead body, the hydrochloric acid and pepsin remaining in the stomach at the time of death will cause softening or gastromalacia in the dependent portion of the stomach wall.

Because in bleeding peptic ulcers (in stomach or duodenum) all the pain disappears as soon as placed on a management in which the free hydrochloric acid is completely combined by alkalies or albuminous foods. The bleeding ceases entirely after ten to fourteen days if the ulcer is uncomplicated, and usually on the second or third day.

Because the very shape of most peptic ulcers (small, round, oval and punched-out) speak for some sort of corrosion.

Because of the fact that many atypical (painless) ulcers are only pea size and yet perforate. This speaks for corrosion, since hunger contractions and digestive contractions with consequent increase on intra-gastric pressure **were surely there and yet produced no pain before perforation.** Corrosion and perforation could easily occur under these conditions providing exposed nerves were not in the path of corrosion.

Because the pain of peptic ulcer may be made to disappear completely even though doubling the intra-gastric pressure (with tartaric acid and soda or by air inflation), providing the free hydro-chloric acid is neutralized.

Because a duodenal ulcer pain is not affected by the intra-gastric pressure of hyper-tonus and yet is relieved by alkalies, albuminous foods, and removal of the corrosive gastric juice by means of the stomach tube.

Because the position of a peptic ulcer can frequently be diagnosed (and confirmed at operation) on history alone. The dorsal position may relieve the anterior wall ulcer and the ventral position may relieve the posterior wall ulcer.

Because the pain in the cardiac end of the stomach ceases within a few minutes after its appearance, while the outlet ulcer pain persists until the entire meal has left the stomach (due to continuous bathing of ulcer in corrosive peptic juice).

Because in peptic ulcers giving positive roentgenologic signs (niche or accessory pocket) these signs, usually disappear entirely within fourteen days time if the entire acid output of the stomach has been neutralized or combined each day and night.

Because in a perforated ulcer the pain does not cease with the sudden release of the intra-gastric tension, even though the stomach remains flaccid because of resulting paresis.

Because with three to seven days of starvation in which no gastric juice bathes the ulcer and during which time there are repeated hunger

contractions and marked hyper-tonus no ulcer pain occurs unless there is present the complication of continued secretion.

Because of the frequent occurrence of jejunal ulcers opposite the gastro-enterostomy opening at the point where the acid gastric juice spurts against it. The pain of jejunal ulcer occurs from one to three hours after meals (the regular corrosion time) and yet the ulcer is extra-gastric and not effected by its contractions and hyper-tonus.

Lesser arguments are that Leub's and Lenz's management with 70 to 75 per cent. cures, are founded on this theory of peptic corrosion, and they have stood unchanged for several decades. Even the success of gastro-enterostomy is credited largely to the alkalinizing effect of bile and pancreatic juice rather than to direct drainage.

Even granting that contraction waves of the stomach, with greatly increased intra-gastric pressure, cause peptic ulcer pain, why is it not just as reasonable to explain the pain by saying that the contractions and increased pressure resulted from the acid corrosion irritating the ulcer?

What is this intro-gastric pressure which we are talking about? Von Pfungen found it from 19 cm. H₂O at the cardia to 162 cm. H₂O at the pylorus. Cannon found from 6 to 8 cm. H₂O at the cardia and 38 to 60 cm. H₂O at the pylorus, though as a rule ranging from 20 to 30 cm. (adult average).

The pain of ulcer may be entirely different from the usual classical pain when the peritoneal covering of the stomach has been penetrated or when the stomach has become adherent to other organs like the gall-bladder, liver, pancreas, etc.

INVERSION OF UTERUS.

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Probably the most unique definition to be found for this anomaly would be that it is *when the uterus is upside down and inside out.* That is, the fundus uteri becomes the lowest and the cervix the highest part of the organ and the external surface becomes the internal.

Frequency: Jardine (1) for the Glasgow Maternity Hospital, found that it occurred three times in 51,290 cases. Winckel (2) had not seen a complete inversion in 20,000, nor Braun (3) a single one in 250,000 cases. Den-

ham (4) had seen one inversion at the Rotunda Hospital, Dublin, in 100,000 cases.

At the Petrograd Lying in Hospital, one of the largest of its kind in all Europe, Beckman (5) had not seen a single case in 250,000 deliveries, while Madden (6) had observed it but once in 190,000 labors in Dublin. W. C. Jones (7) after a study of collecting figures shows an average of one case in 127,767.

Records as shown from the maternities of Detroit Institutions, or those from whom any records could be obtained, shows the following:

Grace Hospital show that they have had 4,247 confinements in the last 28 years, with one case of complete inversion.

Harper Hospital in the last three years has had 2,100 obstetrical cases with no inversions.

Woman's Hospital has had 8,600 confinements with no inversions.

Providence Hospital has had since 1909, 7,200 confinements, with no case of inversion occurring in this series. One case, however, of complete inversion was brought into the service after the patient had been confined at home.

With relation to the foregoing statistics, it is evident that they have been collected from large maternity clinics and that they are valuable as far as they go, but do not indicate in any way the frequency with which inversion may have occurred in women who are confined at their homes. The majority of these large clinics are so organized that the best possible technic is in effect and all assistants in these clinics are subject to orders from the heads of their departments, and we would therefore expect a far greater number of inversions among those treated individually in their own homes and by men who are either ignorant or careless of proper prophylactic measures for its prevention. It is therefore impossible to obtain true statistics in this latter class, inasmuch as the greater proportion of physicians make no reports of them and indeed make no personal case records at all, and so while Jones in his study of collected figures shows but one case in 128,767, this cannot be any criterion of inversion found in private practice. Kehrer (8) places the frequency of all cases as one in 2,000 which indeed seems to me in a general way to tally more perfectly with what we might expect.

VARIETIES.

Inversion of the uterus are of three varieties according to the degree of displacement.

1st. Consisting in a simple dipping in or a cupping of the fundus.

2nd. Where the fundus descends below the os uteri.

3rd. Consisting in a complete descensus through the os and vagina with the whole fundus visible outside the vulva.

This latter condition may be so exaggerated that the vagina is partly inverted and the uterus dragging down the tubes and ovaries making a complete uterine inversion with prolapse.

ETIOLOGY.

Two or three factors are necessary for the production of this phenomenon, pressure from above, traction from below, together with a localized atony or thinness of the uterine walls. Some of the exciting causes are the implantation of the placenta at the fundus, submucous fibroids which have become pedunculated during pregnancy and manual extraction of the placenta. The latter has been known to be an exciting factor in several instances, probably due to the negative pressure set up by removal of the hand in utero, together with the thinned fundal area, assisted by pressure from the hand above. Simply the weight of a large placenta attached at the fundus may be an exciting factor when associated with a marked uterine atony, for in this instance the fundus assumes a cup-shaped appearance and as it descends it becomes a foreign body; in the process of time the remaining portion of the organ becomes active in its contraction and endeavors to expel this depressed portion exactly in the same way and for the same cause that it has formerly done to expel the child.

Exceptional instances of spontaneous inversion have occurred as a result of intra-abdominal pressure; other causes are those of the mother giving birth while in a standing position; short umbilical cord or the cord twisted about the child's neck or body; hard coughing, sneezing, etc., at the end of long wearisome labors.

The two most important causes recorded in order of their frequency, we have purposely placed last in this series (1st) too early adoption of the Crede method, together with its improper use (2nd) traction upon the cord as a means for the detachment of the placenta or a combination of the two, traction from below and compression from above simultaneously.

We cannot escape the view that the greater majority of inversions are due to faulty technic. There are those rare instances in which inversion occurs two or three days after delivery has been made by competent well trained obstetri-

cians, but these are few and we are not interested in that class, but in the ninety and nine which are directly traceable to poor technic at the time of delivery.

J. M. Monro-Kerr (9) Glasgow, states that in making a review of English and Continental literature for the years 1903-5, 23 cases of inversion were reported and in examining them it was very evident that in the majority of cases the occurrence had followed pressure from above or traction from below. William says that this accident is scarcely ever seen when labor is properly conducted.

Out of 100 cases tabulated in a given series, but three were delivered in hospitals; these tabulations, however, are from large clinics where the technic of delivery is controlled by a single individual. It occurs to me that the injudicious use of large doses of pituitrin may be a predisposing etiologic factor.

SYMPTOMS.

Inversion of the uterus is followed by alarming symptoms of shock and hemorrhage, somewhat dependent upon the amount of inversion present, the more complete the inversion thereby pulling down structures from above, proportionately great will be the symptoms of shock. This may reflect very seriously upon the heart through reflex action. Hemorrhage is always a prominent factor and in the recent case demands immediate and urgent attention. When the inverted uterus remains in this position for a considerable time the contraction ring made by this re-duplication may shut off circulation sufficiently to cause gangrene of the portion exposed.

DIAGNOSIS.

If the obstetrician is in attendance at the time inversion takes place and the inversion is sufficiently extensive to protrude from the vulva with the placenta attached, the diagnosis is evident, but such instances where the inversion is not sufficient to propel the fundus through the external parts, very careful examination under the most cautious circumstances must be made. To this end the bladder should first be emptied, for should the inversion have existed for two or three hours or more, the likelihood is that there will be a marked urinary retention and the well filled bladder would be mistaken for the fundus uteri, accordingly it is necessary that the bladder should be emptied so that intelligent manipulation could be made from above. With this preparation, with the

patient anesthetized, one hand above and the other introduced into the vagina, will reveal the pathology.

PROGNOSIS.

According to Crosse (10) one-third of the women with inversion of the uterus, die either immediately or soon after. Patients may die either as a direct result of shock or hemorrhage, but usually a combination of the two. When immediate fatality does not follow, a large number die as a result of infection. To conclude, it may be said that it is one of the gravest of obstetrical accidents.

TREATMENT.

As regards prophylaxis it cannot be too strongly emphasized (1st) that the cord should not be dragged down (2nd) that Credé's method should not be injudiciously employed (3rd) that in no instance should the fundus uteri be so pressed down that indentation is made upon it (4th) that Credé's method should not be employed except when the uterus is in contraction. This last in our opinion is highly important (5th) the obstetrician should remain with the patient until a firm uterine retraction has been established.

The more recent the inversion, the more surely and safe it can be reduced. In the twenty-three collected cases of Monro-Kerr's before referred to, they were all treated by competent obstetricians, yet in three cases they failed and in four accomplished the replacement with difficulty, therefore, it seems evident that considerable patience and sufficient time be employed in attempting a replacement. In instances where the uterus is open and flaccid, replacement can usually be made by introducing one hand into the vagina and with the closed finger and thumb pressed upward on the most dependent portion, the other hand above serving such assistance as the pressure from below would indicate. In the later case, where some time has elapsed between the time of the inversion and the attempt at replacement, Bandl's ring will often be found firmly contracted, and into this narrowed portion we find the difficulty to be overcome. Considerable time with gentle force will usually be productive of good results. Attempting this maneuver too rapidly, may cause rupture of the uterus by the hand within the vagina, while time and patience will usually tire out the muscles forming Bandl's ring, and permit the desired replacement.

In rare instances these maneuvers can be carried out without the aid of an anesthetic on account of the shocked condition of the patient having obtunded her sensibilities, but in the general run of cases a full surgical anesthesia with the patient in a semi Trendelenburg position will be advantageous.

There is a division of opinion among the best obstetricians as to whether the portion first inverted should be the first or last to be replaced, but I think in general this would depend more largely upon the time that had elapsed between the inversion and the attempt at replacement. On such occasions where the placenta remains attached and it is possible to replace both placenta and uterus in toto, this procedure should be attempted.

When only parts of the placenta are attached, these should be removed, the area well disinfecting and the uterus replaced as above indicated. When the uterus has been in a state of sub-acute inversion and considerable involution has taken place, adhesions will have been formed sufficient to make the maneuvers referred to before inapplicable and impossible. When such cases appear, some type of radical operation becomes necessary.

Kuestner's operation for this condition consists in opening Douglas Pouch, inserting the left index finger through the opening and into the cup shaped uterine fundus. If the fundus of the uterus is outside of the vulva, the inverted portion will appear uppermost and therefore easily accessible to the operator.

The longitudinal incision in the medium line divides the cervix at the inverted ring and is carried up the body of the uterus to the fundus. With the liberty given after the division of this inversion ring, the organ may now be re-inverted into its normal position by the finger remaining in the cup shaped portion, while the thumb pushes upward upon the fundus. The fundus is now drawn through the posterior incision through Douglas Pouch where the uterine wall is sown together and the organ returned to the pelvic cavity.

Spinelli's operation has much the same maneuver and answers the same purpose but is made through the anterior vaginal wall by making transverse incision across the cervix as in the case of an anterior colpotomy, pushing the bladder up and gaining admission to the pelvic cavity from the front instead of behind, the other details are followed out much the same as the Kuestner operation.

ILLUSTRATIVE CASE.

On April 10th, 1919, at one A. M., Mrs. C. B. gave birth spontaneously to a baby girl at full term after a moderate labor of ten hours.

The physician in charge who afterward referred this patient to me, waited one hour and when the placenta was not forthcoming, made pressure above with conjoined dragging upon the cord, which resulted in complete inversion of the uterus so that the fundus presented below the vulva. The patient was left in this condition until the following morning when an attempt was made to reduce it. The effort was futile but the patient was allowed to remain at home during the whole day. She was sent to the hospital at eight o'clock the evening of April 11th, when I first saw her. Therefore, a complete inversion had been present for twenty hours. The patient was a robust woman of the working class and presented a ghastly appearance caused by the severe shock and bleeding which had continued from the time of the inversion. Her temperature was 97.5, pulse 140, with blood pressure 110 systolic and 90 diastolic. A blood count which was taken after she was returned to her bed showed 1,500,000 reds with 40 per cent. hemoglobin, thus you can see she had bled an alarming amount. This coupled with the associated factor of shock made a bad prognosis, however, the patient was placed upon the table and a full surgical ether anesthesia was administered. As soon as the anesthesia was sufficient, hypodermoclysis was at once instituted under the breasts. On examination the uterine fundus and body was seen between the patient's thighs, and while the placenta had in a large measure been removed, small portions of it still remained attached. The portions of placenta which were adherent were removed, the whole surface of the endometrium was bathed with ethereal soap and sterile water, followed by a 2 per cent. iodine solution. The patient was then placed in a semi-Trendelenburg position, the left hand inserted into the vagina with the fingers and thumb extended and the uterus pushed up, being careful that the force from below was made in the long axis of the strait, the hand above becoming of equal importance in its effect to replace the organ after the part below was pushed up above the fundus where the right hand successfully assisted in drawing the uterus upward, much the same maneuver that the hand assumes when milking a cow. About fifteen minutes of gentle manipulation succeeded in re-inverting the uterus through Bandl's ring which seemed to be the chief obstacle to its replacement. Several two inch pieces of iodoform gauze one yard in length were separately packed into the uterus and left in such a way that they could be removed singly in thirty-six hours, thus giving no inclination for the uterus to return to its former position because of all of the gauze being removed at one time.

We were fortunate in having a good anesthetist so that little ether was used. The patient was returned to her bed, the foot being elevated and the Murphy drip consisting of tap water, soda bi-carb. and glucose was instituted. The patient remained in the hospital sixteen days with an uneventful recovery. She showed a mild infection which disappeared after two or three days.

REFERENCES.

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2. Winckel *Lehrbuch der Geburtshilfe*, 1893.
3. Braun: Quoted from *Amer. Journal Obstet.*, P. 145.
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5. Beckman, *Zeitschr. f. Geb. u. Gyn.*, 1895, P. 271.
6. Madden: Quoted by Williams, P. 847.
7. Jones, W. C.: Quoted by Graves, P. 482.
8. Kehler *Handbuch der Geburtshilfe*, 1889.
9. Kerr: *Operative Midwifery*, P. 658-9.
10. Crosse: Quoted from *Amer. Text Book of Obstet.*, P. 150.

A REMINISCENCE OF SIR WILLIAM OSLER.

BLANCH N. EPLER, M.D.

KALAMAZOO, MICH.

In the passing of Sir William Osler, Regius Professor of Medicine, Oxford, England, at 13 Norham's Gardens, the world has lost from its midst a remarkable man. Claimed by the United States, Canada, and England, his magnetic personality and master mind has brought about a close relationship between the distinguished members of the Medical Profession of these countries.

During the war his Oxford home being the rendezvous of many of the Medical Profession, this relationship was strengthened.

To us as students in the 90's, the first years of the Johns Hopkins Medical School, there was reflected from this great Clinician the stimulus of the opening up of Medicine as a science, for it was the time of Koch, Pasteur and Lister and he with his brilliant colleagues, Dr. Keny, Welch Flexner, Mall and Halsted of Hopkins, surrounded us with an atmosphere of personal interest, and encouraged research and investigation.

During the last of our four years course, three months was respectively spent in the service of each of these great men and with them we passed practically a half day in operating room or hospital ward or laboratory or autopsy room.

It was the custom each morning for the Clinical Group to await at the Medical Ward Dr. Osler's coming. He was always to the minute and we were greeted by a joyous, scintillating personality, flinging forth repartee from some classic or the Bible or some remark to his resident physician, interne or Clinical Clerk on some research result or case.

Grouping about each bed in turn, we listened, observed and wrote as the great Clinician went over the patient. Nothing escaped him, whether a mark on the skin or a hammer toe, and everything possible was brought into co-relation with the disease and patient and laboratory anticipations. Each patient proved a text

book to us and he was left with an encouraging smile and a feeling of absolute confidence that the case was understood.

Dr. Osler's knowledge was profound; but, always a student in new medical problems and investigations, he kept keenly alert, and had a marked faculty of interesting the students in various pioneer lines of research, opening up the way most generously by providing facilities from the laboratory and materials from the wards of the hospital. Thus truths in physics, or chemistry or physiology were continually disclosed. Dr. Osler was a trained laboratory man and possessed marked knowledge of morbid anatomy.

At this time, among several facts which he impressed upon us, I especially remember those of the fever of endocarditis; the ball valve thrombus at the mitral valve; the ball valve stone at the ampulla of Vater; and the specific lesions of small pox.

Dr. Osler always had a series of similar cases to the one under consideration, which he discussed with regard to the bearing on the disease; and opening up the pathological findings in their detailed relation to the history of the case, he engrafted in his pupils the habit of considering the gross and microscopical picture of the organic lesion in association with each phase of the disease. Even at the end of the fourth year, he impressed upon us that we knew so little, it was better to assume this attitude of mind in starting our practice.

Dr. Osler "stayed" with his students and weekly at his home gathered his so-called "clinical clerks" about him for discussing their cases and unfolded to them, from the time of Hippocrates, the history of the disease as presented in the old editions of the Science and Art of Medicine in his library, which was one of the best in existence. He was always Master of his subject, with a marvelous memory of details of cases, seen even years before, and he possessed a boundless knowledge.

As far back as the 90's, he used to say to his students that he who knows syphilis knows nearly all of medicine.

Sir William Osler was born in Tecumseh, Ontario, in 1849, the son of Rev. F. L. Osler. He was one of a large family, all since leaders in their various professions.

He was graduated at Trinity College, Toronto and studied medicine at McGill, doing research work in London, Berlin and Vienna.

Dr. Osler became early in life interested in nature through Rev. W. A. Johnson, a nature lover, with whom he made a study of diatoms

and used the microscope. Two other clergymen and a Dr. Bovell, who was also a professor of natural Theology, not only instilled into him a similar love of Nature but also a love of Biblical and Classical Literature, thus laying the foundation for his exquisite literary style and expression.

While in London in 1874 at 24 years of age he published that important contribution to medicine on the blood platelets and at 25 he returned to Montreal as a Medical Professor in McGill and in the Smallpox hospital, which position he held until 1884 when he was called to the Chair of Medicine at the University of Philadelphia. Here, he broke through the stereotyped medical teaching held so firmly by Pepper and became associated with Musser, Weir Mitchell and Howard Kelly.

In 1889 he, as the most able Clinician available, was called as Chief of the Medical Clinic to Johns Hopkins Hospital and University where he was ever afterward known by his Colleagues as "The Chief."

The life of Johns Hopkins Hospital and Medical School from 1889 to 1905 was strikingly that of Dr. Osler's influence, and is itself a separate, valuable history for all other medical schools, as it was a marvel of organization and scientific effort.

Among the men Dr. Osler drew from Canada to assist him at Johns Hopkins were Drs. Lewellyn Barker, Thomas McCrae, Fitcher and John McCrae, the composer of "In Flanders Fields." His life with these men and his other colleagues was one of affection and continual round of work and medical uplift.

The Medical School was not opened by the University until an endowment of \$500,000 was obtained, which was largely Miss Garret's donation, when she stipulated that the school must be of a certain high standard and must admit women on the same par as men. It was opened in 1893, four years after Dr. Osler's going to the Hospital.

Dr. Osler's entrance into Baltimore brought order out of chaos in the medical fraternity. His rare character of kindness and affection for all men, even one-half way good, his keen appreciation of the doctor's work in small towns and country practice with few advantages in their broad experience of caring for all varieties of diseased conditions, made him a friend of each and every physician in country or city. He mastered among men and secured co-operation

especially in tuberculosis, syphilis preventive medicine, he brought into play

some of the great factors now in force in connection with these conditions.

He founded the Laennec Society in 1912, the first in the world to devote itself to the study of Tuberculosis, and brought forth in 1889 the first public discussion of the value of outdoor night air in consumption, while in 1904, he was instrumental in helping to bring about the first Tuberculosis Exposition under the State Board of Health, in this country.

He inaugurated home visiting of the dispensary tuberculosis cases and a special department of tuberculosis, from which have grown the Phipps Laboratory and department of Tuberculosis.

In 1889 he aroused Baltimore and Maryland to the low standard of medical schools and practice, which culminated in the raising of the standard of medical schools, not only in Maryland but in the United States, and in the legislative bills in Maryland in regard to medical practice.

Baltimore at this time had over-ground sewerage, which any morning crossing the alleys and streets, we would slip into and might be covered with the days dishwashings. This system was shown to be an aid in keeping up the large typhoid rate.

Dr. Osler moved the American Public Health Association to action in the eradication of typhoid and the installing of proper water and sewer systems in Baltimore.

The local Medical Societies and Library he drew out from their lethargy and made of them a marked success, putting into them the spirit of giving standing to doctors with honesty of purpose and reaching those who had something to give but knew not how to give it, and providing the printed page that all might be kept up to date.

Some of his own 700 publications in these libraries show frequent use and the following passage, which was especially well thumbed, suggested the personal influence of his counsel upon others.

"The measure of value of the nation to the world, is neither the bushel nor the barrel, but mind: wheat and pork, though useful and necessary, are but dross in comparison to the intellectual products which alone are imperishable."

This passage especially seems applicable in these times of commercialism within and without the medical profession.

The organization of the medical work and clinic at Johns Hopkins stands prominent in the history of such work. It was original and unique, embodying all the best in this country

and abroad, in order that the medical students be made a part of the practical functioning work of the ward, laboratory and dispensary, and that practical technical knowledge might be instilled rather than that from didactic lecturing.

Dr. Osler's clinical work was an art and science in itself an ideal for medical teaching.

In 1905 he was called from Johns Hopkins University to Oxford, England as Regius Professor, from which position he has been intimately and continually in touch with events and conditions in his old field of labor. In 1911 he was knighted.

The war took his son and only child—a young man—bringing to him, as to Roosevelt, a crushing bereavement, and like Roosevelt, a short time afterwards, on December 29th, 1919, he left us, after a month's illness with pneumonia complicated by empyema.

Only on December 25th, he had sent greetings to Johns Hopkins.

Dr. Osler was always troubled by the misquoting in the press of his having said that a man of 60 is beyond usefulness and should be chloroformed. The facts are these: In delivering an address to the students of the University proper in Baltimore—not the medical students—and in urging on them the value of their young years—he quoted from an old time doctor the above remark. This did not represent his views, but feeling that a denial could never overtake the report, he made none through the press.

Loving his fellow men, saying evil of none, giving all his powers to the profession, encouraging all virtues and culture, and beloved by all, this great character, this ideal physician has left us, to be deeply and sincerely missed as have few others.

TECHNIC OF NERVE SUTURE AND NERVE GRAFTING.

By Charles A. Elsberg, M.D., N. Y. The Journal of Amer. Med. Ass., Vol. 73, No. 9.

From the beginning of a peripheral nerve operation to its end a very perfect technic is necessary. The freeing of the ends of a divided nerve and the excision of the surrounding scar tissue with the least injury to the delicate nerve structure, the perfect control of bleeding, the accurate sectioning of nerve bulbs until good nerve fibres are exposed, the proper approximation and suture of the nerve ends without tension—all these and many other details are of great importance.

1. Identification of the Injured Nerves.—Expose a normal part of the nerve or nerves below and above the lesions, work from normal to scar tissues, then identification of injured nerves and their branches is always possible.

2. Exposure.—The lower end of a divided nerve should always be exposed and freed first because it is the degenerated end. The upper end should be exposed for as short a time as possible and should be handled with special care. Strong traction should never be made on it, and it should not be stretched in the effort to approximate the ends of a divided nerve.

3. Examination for Nerve Bundles.—If there is no gross separation of the ends of the nerves but only a bulbous thickening, the bulb should be minutely examined before being sectioned transversely. No matter whether the patient presents the symptoms and signs of a complete interruption or not, the bulb should be carefully incised in a longitudinal direction in the search for nerve bundles which can be saved. In a considerable number of patients, some perfectly good nerve bundles are preserved on the surface of or in the deeper parts of the bulb, and such nerve bundles may be freed from the scar tissue and not divided. When these nerve bundles run on the surface of the bulb, they can be isolated without much difficulty. When they run thru the center of the bulb their isolation and preservation may require much patience.

4. Excision of the Bulbous Enlargement or of End Bulbs.—When there is a complete anatomic discontinuity of the nerve, the bulb or end bulbs should be divided transversely, with a sharp

scalpel, in successive sections until normal funiculi can be readily recognized. As the upper end of an injured nerve is often swollen, perfectly good funiculi may present an edematous or glairy appearance. Usually there is fairly active bleeding from the intravenous blood vessels when normal funiculi are reached.

The ideal application of the ends of the nerve would be one in which the cut end of each funiculus is placed exactly opposite to its corresponding end, but in practice this is impossible.

The Divided Ends of a Nerve.—The approximation should always be made without tension. In the majority of instances, this can be accomplished by freeing the nerve ends—especially the peripheral part—for a considerable distance. In this procedure, due consideration should be given to the location of branches, and care should be taken that important sensory and motor branches are not injured.

The suture of the divided ends of a nerve is a very delicate procedure. For suture material use Carrel needles with very fine silk. For the actual union perineurial stitches are used. All of the perineurial sutures should be passed before they are tied, care should be taken that the sutures just bring the funiculi into opposition. If the sutures are tied too tightly, the funiculi are bent at their ends with a resulting poor approximation. The best approximation can be obtained by mattress sutures.

Transplantations of the nerve to a more superficial level are sometimes necessary. To separate the line of union from the bone, muscle or fascia, plastic operations must often be performed to surround the line of union with a cuff of tissue and to protect it from the surrounding scar tissue.

As all experience in human surgery and animal experiments have shown, a direct end to end suture is far preferable to a nerve grafting. If the ends of a divided nerve cannot be approximated by all the methods described, a graft must be inserted between the ends of the nerve.

If the condition of a nerve permits it, a neurolysis is always better than a resection and suture, and a resection and suture far better than a resection and grafting. The result of neurolysis, in cases in which it may properly be employed, are very satisfactory.

Official Minutes

of the

Mid-winter Meeting of the Council

Detroit, January 13 and 14, 1920

The Council, in response to call of its chairman, met in regular session in the Wayne County Medical Society Building in Detroit, Jan. 13 and 14, 1920.

FIRST SESSION.

The first session was called to order by the chairman, W. J. Kay, at 7:30 p. m., Jan. 13, 1920, with the following councillors present.

W. J. Kay, J. McLurg, C. T. Southworth, A. L. Seeley, J. B. Jackson, W. G. Bird, S. K. Church, L. W. Toles, Guy Kiefer, Frank Holdsworth; President, C. H. Baker; Treasurer, D. Emmett Welsh; Associate-Editor, Guy L. Connor; Geo. H. Frothingham, Chairman of the Committee on Civic and Industrial Relations and the Secretary-Editor F. C. Warnshuis.

ANNUAL REPORT OF SECRETARY-EDITOR.

The following report was read:

ANNUAL REPORT 1919 SECRETARY-EDITOR.

To the Chairman and Members of the Council
Of the Michigan State Medical Society

Gentlemen:

In compliance with the provisions of our Constitution I am submitting to you and through you to our component members, my Annual Report as Secretary-Editor for the year nineteen hundred nineteen.

I would indeed be remiss if I failed at the very outset to record my appreciation for the able and splendid manner in which D. Emmett Welsh conducted the affairs of this office during the period in which I was in the Service. Personally, I know the extent of time and energy he devoted to the work, which cannot be fully appreciated except one be intimately familiar with the innumerable details that arise in this office and the many perplexing problems that present. Doctor Welsh rose, as only he can, to the occasion and to him there is acknowledged a lasting debt of appreciation.

He served this Society and through it our country equally as honorably and valiant as did they who enlisted in the Medical Corps.

FINANCIAL STATEMENT

I present the following financial statement and exhibits of resources, receipts, and expenditures certified to by a public accountant:

January 6, 1920.

To the Council of the Michigan State Medical Society.

Gentlemen:

I have completed the examination of the books and accounts of the Michigan State Medical Society for the year ended December 31, 1919, and am pleased to submit the following exhibits:

EXHIBIT A.

Trial Balance, December 31, 1919.

Bond Account	\$ 4,300.00	
Liberty Bond Account..	3,500.00	
G. R. Savings Bank ----	925.78	
Accounts Receivable ----	794.69	
Journal Expense	7,781.23	
Society Expense	2,943.59	
Reprint Expense	644.90	
Annual Meeting Expenses	503.19	
Council Expense	196.87	
Present Worth Account---		\$10,739.80
Journal Subscriptions ----		4,045.53
Advertising Sales		3,545.32
Membership Dues		2,276.25
Reprint Sales		527.48
Interest Received		389.00
Outside Subscriptions ----		30.62
Sale of Extra Journals---		8.50
Defense Fund		27.75
	\$21,590.25	\$21,590.25

EXHIBIT B.

REVENUE—

Statement of Revenue and Expenses for 1919.

Journal Subscriptions ----	\$ 4,045.53	
Advertising Sales	3,545.32	
Membership Dues	2,276.25	
Reprint Sales	527.48	
Interest Received	389.00	
Outside Subscriptions ----	30.62	
Sale of Extra Journals ---	8.50	\$10,822.70

Expenses—

Journal	\$ 7,781.23	
State Society	2,943.59	
Reprint	644.90	
Annual Meeting	503.19	
Council	196.87	\$12,069.78

Net loss for the year 1919 \$ 1,247.08

EXHIBIT C.

Balance Sheet, January 1st, 1920.

ASSETS.

CURRENT—

Checking Account at G. R.	
Sav. Bank	\$ 925.78
Accounts Receivable	794.69

\$ 1,720.47

SECURITIES (In Custody of Treasurer.)

Liberty Bond Account	\$ 3,500.00
Masonic Temple Bonds ..	2,300.00
Citizen's Telephone Com-	
pany Bond	2,000.00

\$ 7,800.00

Total Assets

\$ 9,520.47

LIABILITIES.

CURRENT—

Due Defense Fund

\$ 27.75

Net Present Worth.....\$ 9,492.72

PRESENT WORTH.

Represented by Jan. 1, '19 \$10,739.80

Net Loss for year 1919 1,247.08

Net Present Worth,

Jan. 1, 1920

\$ 9,492.72

The checking account at the Grand Rapids Savings Bank was reconciled as of December 31, 1919.

The Securities in the custody of the Treasurer, Doctor D. Emmett Welsh, were exhibited to me and found to be correct.

Am pleased to advise for your information that the books and accounts of the Michigan State Medical Society are in good condition and the above Balance Sheet, Exhibit C, in my opinion represents the true financial position of the Michigan State Medical Society as of January 1st, 1920.

Thanking you for the work, and awaiting your further instructions, I am

Yours very truly,

Walter H. Shultus,

Certified Public Accountant.

January 6, 1920.

To the Council of the Michigan State Medical Society.

Gentlemen:

The following will convey to you the amount of funds of the Michigan State Medical Society in my hands for the year ended December 31st, 1919:

Citizens Telephone Co.

Bonds, Nos. 139 and 140 \$2,000.00

Masonic Temple Bonds:

18 \$100.00 bonds, Nos.
199 to 216 inclusive,
5 \$100.00 bonds Nos. 225
to 229 inclusive

2,300.00

Liberty bonds, First Issue

3½%; No. 8450

500.00

Liberty Bonds, Second Issue

4%; No. 1,439,859

1,000.00

No. 661,282

500.00

Liberty Bonds, Third Issue

4¼%; No. 1,110,074

1,000.00

No. 633,293

500.00 \$7,800.00

The following will convey to you the amount of funds on hand in the Defense Fund for the year ended December 31st, 1919:

Liberty Bonds, Second Issue

4%; No. 661,283

\$ 500.00

Balance in checking account

at Peoples' State Bank

at Detroit, Mich.

132.20

Total

\$632.20

Respectfully submitted,

D. Emmett Welsh,
Treasurer.

COUNCIL EXPENSE, 1919.

Hotel Fort Shelby

\$ 42.20

Drs. D. Emmett Welsh and

A. Wertz

28.00

Dr. J. B. Jackson

14.50

Dr. C. T. Southworth

30.00

Dr. W. J. DuBois

18.98

Dr. W. G. Bird

6.00

Dr. F. Holdsworth

21.72

Dr. S. K. Church

9.30

Dr. J. McLurg

13.54

Dr. A. M. Hume

12.63

\$196.87

ANNUAL MEETING.

Hotel Statler, Dr. Welsh and

A. Wertz

\$ 26.40

Dr. D. Emmett Welsh, railroad

fare Drs. Welsh and Wertz

25.00

W. H. Whitford, stenographers

429.80

Dr. W. G. Gillette, guest

5.00

Dr. Dean Lewis, guest

25.00

Gradesman Company, blanks ..

13.50

Thaddeus Walker, M.D., Treas.

Wayne Co. Med. Society

194.43 \$719.13

Dr. J. W. Vaughan, Exhibit Committee

215.94

\$503.19

A. M. A. DELEGATES' EXPENSES.

Dr. D. Emmett Welsh

\$125.00

Dr. J. D. Brooks

125.00

Dr. A. W. Hornbogen

165.00

Dr. Walter J. Wilson

117.77 \$532.77

The reported loss of \$1,247.08 for the year is accounted for by:

1. Diminished membership receipts. It must be remembered that no membership dues

were received from members in the Service. County Societies only remitted for subscriptions to the Journal.

2. For the first time, the expenses of our Delegates to The American Medical Association were paid. This incurred an expenditure of \$532.77. It is recommended that an expression of sentiment be recorded that our parent organization, the A. M. A., assume all or at least part of the Delegates' from State Societies expenses, inasmuch as they serve not only for the good of the profession of the State that sends them but also for the profession of the entire country.

3. Increased cost of postage is explained by increased correspondence in getting out the Victory number, remailing of photographs and a letter campaign for members.

Our present worth January 1, 1920, is \$9,492.72.

Here it may be well to note that the funds of our Medico-Legal Committee require replenishment. The splendid work done by the Chairman and the good that has been accomplished is known to all. We cannot afford to limit the work of the Medico-Legal Committee or increase the difficulties that ever confront it by hampering it with insufficient funds. It is recommended that an amendment be presented to the House of Delegates increasing the State dues to \$5.00 per year. Of this added revenue, one dollar and fifty cents, thus to be derived, one dollar to be placed to the credit of our Medico-Legal Committee and fifty cents to our Society for committee work. The appropriation to our Society for Committee work is indicated and will be explained in further detail in my comments on Society work.

THE JOURNAL.

The net receipts of the Journal, composed of dues and advertising, amounted to \$7,590.85; the net cost was \$7,781.23.

By reason of persistent effort we are gradually increasing our advertising receipts which during the year amounted to \$3,545.32. Our December issue contained \$369.46 of advertising; the January issue, \$468.82; and the February issue will contain \$512.99. Whether or not this increase will be maintained during 1920 depends upon the business world's prosperity and our members' patronage of our advertisers. I cannot but urge that each Councillor continuously remind the members in their respective districts to support their Journal by patronizing its advertisers.

The net cost of each copy of the Journal is 18 cents, for which each member pays 12½

cents. It will be apparent that without advertising receipts the present Journal could not be mailed to our members. During the year 636 pages of reading matter were printed in the twelve issues. Our mailing list now contains 2638 names to whom a copy is sent each month.

The non-ending increase in paper, ink and labor cost continues to add to our financial difficulties. Upon our return from Service we secured information upon the paper market and guided by that information two carloads of paper, a year's supply, was contracted for. Had this not been done our Journal would be costing us approximately \$40.00 more per issue today on account of scarcity of paper and its increasing price from month to month. Likewise we became cognizant of the labor situation and after considerable persuasion we induced our printer to enter into a flat contract for printing our Journal for the ensuing year. We were disinclined to accept his proposition of cost plus ten per cent. The contract now in effect is saving us from \$90.00 to \$110.00 per month. I attach letters from our printers revealing how our contract has served to our financial advantage. In 1915 an average issue cost us \$464.11; in 1916, \$431.81; in 1917, \$479.74; and in 1918, \$496.39.

These and other business details of the Journal call for constant alertness and detailed attention. In spite of our contract each issue presents new and old difficulties so that the task of getting out each number calls for almost double the work that was required three and four years ago and quadruple that of eight years ago. I cannot convey in words the labor and time required in editing and getting out the Journal. At times it is indeed disheartening.

As to its value, appearance and subject matter, this appraisal must be made by the Council and our members. We have in mind some new features but from present business conditions it is not deemed prudent to institute them. This is certain, that the Journal has not exhausted its possibilities, and undeveloped fields but await stabilization of industrial affairs.

Certain specific requests for instruction as to financial matters pertaining to the Journal will be presented in a special communication.

Editorially our policy is to continue to cause each issue to contain something of educational value for every reader and to inspire and achieve co-operative action on the part of our members as a whole to conserve and protect their professional and material interests.

If our policy merits criticism, if our results have been deficient, we invite your constructive suggestions and instruction. We are not unaware of the fact that cost and limited space have prevented our becoming a medium for the scientific discussions and investigations of several special organizations that exist in this State. We do feel that these interests should be served by our publication and that this literature should be incorporated in our Journal. It is recommended that steps toward making such provision be undertaken.

SOCIETY WORK.

In commenting upon the present condition of our Society and its component units one cannot help but experience an avalanche of conflicting thoughts that present themselves when given to retrospective review and speculation as to the future that awaits. As did every industry, trade, business and profession, so also did the medical profession of Michigan experience the vicissitudes of these bellicose days. Proudly may we hold our heads when we recall the splendid percentage of our members who went forth to active Service and of whom all but four were permitted to return to their homes and friends.

Victor Clare Vaughan, Jr., Detroit, Lieutenant Colonel—Consultant, died in France, June, 1919.

W. L. Miller, Saginaw, Killed in action, October 26, 1918.

A. C. McCurdy, Battle Creek, 33rd Engineers, died in France, Nov. 28, 1918.

James A. McQuillan, Jackson, killed in service, October 26, 1918.

These made the Supreme Sacrifice. No further eulogy or words of mine can increase the effulgent glory of the subscription of their lives to the cause for which we fought. But would it not be well that our Society provide and place in our State University Medical School a suitable tablet recording the names of these, our honored dead, that posterity for all time may have a visual reminder that these our professional brothers gave their lives for humanity's sake in that greatest of all World's Wars? We tender this suggestion for your consideration.

By resolution of the House of Delegates and the Council, the dues of all members in the Service were remitted. Consequently, our total receipts of dues for the year were markedly decreased. From our best obtainable figures 753 doctors of Michigan entered active service.

This exodus of members, added to the heavy duties falling upon those who remained at

home caused an appreciable slump in Society activity and organizational work. Then as readjustment evidenced itself, numerous changes of locations began to be recorded. There was a more or less general shifting of the profession. The problem presented of securing the affiliation of former members with the County Society of their new locality.

Early in September a questionnaire was sent to County Secretaries and the following data secured:

	No. of Phys. in County	No. of Phys. Eligible	No. of Mem. in Society
Alpena	-----		14
Antrim	12	12	4
Barry	-----		2
Bay	65	63	58
Benzie	8	8	8
Berrien	75	60	31
Branch	30	30	14
Calhoun	140	132	105
Cass	-----		5
Cheboygan	15	15	11
Chippewa-Luce-Mackinac	25	24	25
Clinton	23	23	20
Delta	21	21	20
Dickinson-Iron	-----		16
Eaton	35	35	32
Genesee	135	125	94
Gogebic	22	21	15
Grand Traverse-Leelanau	30	30	24
Gratiot-Isabella-Clare	58	56	33
Hillsdale	-----		13
Houghton	64	60	48
Huron	20	20	12
Ionia	26	26	22
Ingham	-----		65
Jackson	63	60	50
Kalamazoo	-----		130
Kent	238	189	154
Lapeer	34	34	25
Lenawee	55	50	32
Livingston	14	14	6
Macomb	44	41	20
Manistee	21		12
Marquette	41	39	37
Mason	-----		8
Mecosta	18	15	13
Menominee	14	14	10
Midland	9	9	9
Monroe	30	27	25
Montcalm	34	30	21
Muskegon-Oceana	58	53	53
Newaygo	13	13	8
Oakland	78	78	55
O. M. C. O. R. O.	-----		12
Ontonagon	8	8	7
Osceola-Lake	15	15	4
Ottawa	45	32	34
Presque Isle	-----		1
Saginaw	78	78	58
Sanilac	27	26	14
Schoolcraft	7	7	7
Shiawassee	40	40	24
St. Clair	-----		46

	No. of Phys. in County	No. of Phys. Eligible	No. of Mem. in Society
St. Joseph -----	32	32	3
Tri -----	24	24	20
Tuscola -----	35	35	25
Washtenaw -----	105	85	71
Wayne -----	1500	1200	957
	3483	3009	2642

On December 31, 1918 we had 2291 members. On December 31, 1919 our members in good standing numbered 2642, or a gain in membership for the past year of 351. We lost 21 members by death during 1919. The high membership of the past was in 1917 when we had 2504 members enrolled. We are now 138 over our largest previous membership. On August 1st, 1919, our membership was 2426. During the last four months of this year we added 216 new members. Credit for this showing is due to the splendid work and effort of County Society officers, a campaign by mail, Journal editorials and personal effort.

Barry County, dormant and without meetings for three years, is once again an active Society with full membership. Councilor Du-Bois and your Secretary attended its resurrection meeting.

There remain, as reliably as it is possible to estimate, about 367 eligible physicians in the State who are not members. It will be our purpose to achieve their affiliation during the coming year. So much for our membership strength.

It is the future that now concerns us. Looming up and with further reaching influence, the propaganda of Compulsory Health Insurance threatens to institute such regulations, plans and methods that prophesy the upheaval of the entire profession and threatens to overthrow our present relationship of patient and physician. Inspired, furthered and agitated by a certain coterie of would-be reformers, determined to force upon us this Russian-Prussian system, indications are clear that they will succeed unless the profession of Michigan and of the Nation become aggressively active to counteract and defeat this Bolshevism movement. President Baker has appointed a most efficient committee on Civic and Industrial relations with Doctor Frothingham as Chairman. This Committee has been splendidly active. I have invited Doctor Frothingham to be present at this session and discuss before you plans for organizational activity to protect our members' interests.

REGIONAL CLINICAL MEETINGS.

Minnesota, Wisconsin, Illinois and a few other States successfully conduct throughout their states series of district clinical meetings. These are held at stated periods and continue two or three days and are conducted by selected specialists. Such meetings have experienced exceptional co-operation and support from medical men. They may be likened to Post-Graduate Courses. From sentiments expressed it is recommended that the Council present such plan for approval by our House of Delegates and institution, if the House concurs, in the fall of 1920.

INCREASED DUES.

The suggestion, and not recommendation, of increasing our dues is made merely for the consideration as to the advisability of doing so. Certain we are that the organizational activity that the next few years will demand will increase our Society expenses. The appropriations now made and expenses assumed exceed our income from dues. Whether or not in the meeting of these expenses we shall draw upon our reserve fund or increase our dues, merits consideration.

CENTRALIZATION OF MEDICINE.

There is no denying that two sides exist in the problem of centralization of medicine in Michigan. Whether or not the time has arrived to determine which side shall receive our endorsement is likewise debatable. Nevertheless it is incumbent that this subject should receive careful and unbiased investigation with a view point of attaining a registration of dependable facts and a careful consideration of the results that will accrue in order that intelligent judgment may be exercised and thus there be established a line of activity that will accomplish the proper solution of the problem. This is requisite in order that such a centralization may be achieved and the results thereby attained exercise a universal professional benefit that will not be limited by the boundary lines of Michigan.

I hesitate somewhat in even bringing up this subject that has in the past begotten so much of rancor and dissension over a period of more than a quarter of a century. I am doing so now because I am persuaded that as men of today we are endowed with faculties that expand beyond the boundaries of cities or counties, and with that broadened view point it will be possible to eliminate local and selfish desires and cause them to give way for the intrinsic merits of the main proposition.

It is a problem that concerns the profession as a whole and its solution is sought for the benefit of the profession as a whole and not for that of a single community. If at the end of painstaking investigation and consideration the conclusion indicates that such a centralization had best be established in either Detroit or Ann Arbor or possibly elsewhere, the first and most difficult step will have been completed. Thereafter concentrated development efforts will produce all that which will be sought for.

It is suggested then that a committee composed of three members of the Council present the matter to our House of Delegates for the adoption of a resolution that will create a representative state committee charged with the duty of presenting a solution of this question which is to be submitted to the whole profession for final action.

Much more might be said upon this subject but is purposely refrained from at this time. I do urge that the Council initiate the submission and consideration of the problem for the good of the profession of Michigan.

In the January issue of the Journal's editorial pages we published an outline of fourteen suggestions as a plan for County Society activity. We are certain that if the officers and committees of County Societies institute this plan that the coming year will record the attainment of a high degree of organizational activity and influence.

In concluding this report I wish to incorporate my sincere appreciation of the confidence imposed and the consideration extended. We have ever had but one purpose—to conduct the affairs of this office for the greatest good of the whole profession and not for any individual or group of individuals. If offense has been given it is because we would not lend our efforts to the aspirations of some and so subsidize the interests of our members as a whole. We have endeavored at all times to adapt our efforts and work to the welfare of the Michigan State Medical Society—a compact, representative, affiliation of the doctors of Michigan.

All of which is respectfully submitted.

F. C. Warnshuis, Secretary-Editor.

This report was referred to the several committees of the Council.

MEDICO-LEGAL COMMITTEE REPORT.

The following report was submitted:

Detroit, Jan. 10, 1920.

To The Council Michigan State Medical Society.
Gentlemen:

For the first time in over ten years existence, this Committee is obliged to appeal, through you, to the members of the State Society for more funds with which to carry on this work. We have drawn out all our Reserve Fund except \$500, and will soon receive bills which will exhaust the balance. This condition of affairs is partly due to the war, which materially reduced our income without especially lessening our responsibilities, and since the war, has led to a greatly increased cost of trial cases as a part of the general increased cost of living.

The direct cause, however, is an unusual number of hard fought trial cases. One case alone, twice tried, cost us about \$1,700, and we understand this case is to be carried to the Supreme Court by the plaintiff. Another cost us over \$600—bills yet to be presented for the Supreme Court, where we won; and we expended about \$600 in disposing of two Upper Peninsula cases. These are mentioned to indicate the cost of defense in certain cases.

There is no way of curtailing expenses in this work. If the cases arise they must be defended regardless of cost. Cheaper attorneys would be most expensive for the unfortunate individuals thus defended and ultimately for the entire Michigan profession. That we have been able to try a total of nearly seventy-five cases, three of them being carried through the Supreme Court and two having been twice tried in the Circuit Court with an income of but one dollar per year per member, shows well our economy of management.

We think, however, that the time has now come when the profession of Michigan should endorse this work by giving us more money to work with. Since we adopted the policy of having Mr. Barbour try all cases we have not lost a case which we directly handled—a record which speaks for itself. We have educated the profession quite generally to see that malpractice cases are usually blackmail, and it has become increasingly difficult in this state for the plaintiff to secure the expert testimony necessary to take his case to the jury. We have twice during 1919 encountered experts from Chicago, but the imported expert never makes as much impression on the Jury as a well-known local doctor.

We think we must face the fact that the Compensation Act has curtailed damage suits against corporations to such an extent that attorneys are willing to take greater chances and spend more money in suits against doctors than formerly.

It is suggested to the Council that the next session of the House of Delegates should amend the By-Laws so as to place two dollars per member per year in the Medico-Legal Fund. The number of cases reported to us during 1919 has slightly decreased, but the number of cases tried has increased.

Respectfully submitted for the Committee,
Frank Burr Tibbals, Chairman.

Dr. Geo. H. Frothingham, Chairman of the committee on Civic and Industrial Relationship, presented a statement of the problems that confronted his committee and the steps that were being taken to solve them. A gist of one of the problems is given in the editorial pages of this issue of the Journal.

The members of the Council entered into an informal discussion and outlined the direction of activity the committee on Civic and Industrial Relations should pursue.

Adjournment was taken at 10:30 p. m. till 9:30 a. m. Jan. 14, 1920.

SECOND SESSION

The Chairman called the Council to order at 9:30 a. m. Jan. 14, 1920, with the following members present: W. J. Kay, L. W. Toles, J. McLurg, A. L. Seeley, C. T. Southworth, J. B. Jackson, W. H. Parks, Frank Holdsworth, W. G. Bird, W. T. Dodge, S. K. Church, W. J. DuBois, President C. H. Baker, Treasurer D. Emmett Welsh, Secretary-Editor F. C. Warnshuis.

The Publication Committee, A. L. Seeley, Chairman, submitted the following report:

Your Publication Committee recommends:

1. That the policy of giving free reprints be discontinued.
2. That authors be supplied with but three illustrations per article—additional cost of illustrations to be defrayed by the author if a larger number is desired.
3. That outside subscription to non-members be increased to five dollars per year.
4. That the scope of the Journal be enlarged to provide a medium for the publication of scientific papers of associated special medical societies of Michigan. Such papers, when deemed advisable, to be edited by the Publication Committee and Editor.

A. L. Seeley.

L. W. Toles

F. Holdsworth.

On motion, the report was concurred with and adopted.

Your Committee on Finance respectfully recommends as follows:

1. That the State Society defray the expense of the annual meeting at Kalamazoo except such special entertainment features as may be furnished by the Kalamazoo Academy of Medicine.

2. That the receipts derived from the sale of exhibits be credited to the State Society.

3. That the secretary engage competent stenographers for the House of Delegates, General Sessions and Sectional Meetings. The Secretary-Editor is hereby instructed to publish the discussions of sectional meetings without submitting them for corrections. Corrections of grammatical errors to be made by the Editor.

4. That only the actual hotel expenses of guests of sections be paid.

5. That the annual dues of the Society be raised to \$5.00 per member on Oct. 1, 1920.

6. That two dollars of the annual dues be credited to the Medico-Legal Committee commencing Oct. 1, 1920.

7. That the request of the Medico-Legal Committee for a loan of \$1,000 be granted.

8. That the auditor's report be accepted.

C. T. Southworth.

S. K. Church.

The recommendations of the Finance Committee were discussed, section by section and then on due motion its recommendations were concurred in and the report adopted as a whole.

The Committee on County Societies presented the following report:

Your committee recommends:

1. That a suitable tablet be erected in the Medical Building of the University of Michigan in honor of the four members who made the supreme sacrifice during the recent war. That the Chairman of the Council appoint a committee of three to select a suitable tablet, unveil it at the annual meeting in Kalamazoo and present it to the Medical School.

2. That it be recommended to the House of Delegates that it take action toward securing Regional Clinical meetings.

3. That the report of the Committee on Civic and Industrial Relations be printed in the Journal.

4. That the Program Committee arrange for a general meeting on the morning of the second day of our Annual Meeting, for the discussion of the problems of the Committee on Civic and Industrial Relations.

5. That the House of Delegates meet at 2 p.

m. and 7:30 p. m. on the first day of our Annual Meeting and at 8 a. m. on the second and third days.

6. That the plan outlined for County Society activity as published in the January Journal be endorsed.

J. McLurg.

G. L. Kiefer.

J. B. Jackson.

After discussion of each paragraph the report was adopted as a whole.

Moved by Councillor Jackson, supported by Councillor Southworth that the Secretary prepare necessary amendments to our constitution and By-laws as recommended in these several reports for action by the House of Delegates. Carried.

Moved by Councillor Toles, supported by Councillor Bird that each Councillor present to the Society in his district the subject of Compulsory Health Insurance. Carried.

Moved by Councillor Dodge, supported by Councillor Holdsworth that the Chairman of the Council submit a copy of his annual report to

the House of Delegates to each member of the Council two weeks before the annual meeting. Carried.

Moved by Councillor Seeley, supported by Councillor Toles that an honorarium of one hundred dollars be paid Dr. Welsh for his services as Treasurer this past year. Carried.

Moved by Councillor Southworth, supported by Councillor McLurg that the Chairman cast the unanimous vote of the Council for reelection of F. C. Warnshuis as Secretary-Editor for the ensuing year. Carried. The Chairman did so cast and declare the election of the nominee.

Moved by Councillor Southworth that Dr. Welsh be elected treasurer for the ensuing year. Supported by Dr. Dodge and carried.

Moved by Councillor Jackson supported by several that a vote of thanks be given by the Council to Dr. Welsh for his work during the absence of the Secretary-Editor. Carried.

There being no further business the Chairman declared the meeting adjourned.

W. J. Kay—Chairman.

F. C. Warnshuis—Sec'y.

ANNUAL MEETING

Kalamazoo

May 25h, 26th and 27th, 1920

PLAN NOW TO ATTEND

Special Program—National Speakers
Well—A Regular up to the minute
Meeting.

The Journal

OF THE

Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

A. L. Seeley, ChairmanMayville
L. W. TolesLansing
R. S. BucklandBaraga

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All communications relative to exchanges, books for review, manuscripts, news, advertising, and subscription are to be addressed to F. C. Warnshuis, M.D., 4th Floor Powers Theater Building, Grand Rapids, Mich.

The Society does not hold itself responsible for opinions expressed in original papers, discussions, communications, or advertisements.

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February, 1920

Editorials

ANNUAL MEETING.

The Council has selected the dates of May 25-26-27 for the holding of our Annual Meeting this year in Kalamazoo.

The Local Committee on Arrangements consists of Drs. C. E. Boys, Chairman; B. A. Shepard, E. P. Wilbur, Herman Ostrander and L. H. Stewart.

On account of a number of important matters to come before the House of Delegates, its first session will be held at 2:00 p. m., the afternoon of the first day, 7:30 p. m., that evening and at 8:00 a. m. on the 26th and 27th.

Further announcements will appear in succeeding issues of the Journal.

UNIVERSITY CLINICS.

Announcement has been made of the holding of monthly clinics, consuming two days, at the University Hospital and to which the profession is invited. The purpose being to provide the doctors of Michigan with an oppor-

tunity of witnessing modern diagnostic methods and treatment. Further, to create and cement a closer relationship between the Medical Department of the University and the practitioners of the State. The first of these clinics was held on January thirteenth and fourteenth.

For some years there has existed a seeming apartness between the profession and those connected with the University Medical Department. In certain instances there has been a bitterness and on the whole there has been a general misunderstanding that has grown while no one made the effort to bring about a clarification of the situation. During the past few months changes and innovations have been instituted and reorganization of the work at the University Hospital undertaken. Indications are that this year will witness a confidence-inspiring administrative policy being established and better scientific work resulting all along the line.

We have no hesitancy in stating that these monthly clinics will be well worth attending. The two days of time devoted by a doctor in attending them is the best investment possible—he will be a better and abler man for having done so. Each one will return home inspired to do better work based upon modern scientific fundamentals and practices thereby bringing to each community some definite good as the result of this clinical plan. We anticipate likewise a clearer understanding and a closer relationship between all concerned.

By way of suggestion we trust that those in charge of these clinics will not have overlooked making provision for the comforts of the visiting doctors. In the past Ann Arbor hotel accommodations have not been very satisfactory and it will be well worth while that their managers be induced to make provision for the special care of the clinic visitors and establish some modern improvements in their rooms.

Another suggestion—we as a State Society have never met in annual session in Ann Arbor in over twenty years. If ample dormitory and hotel accommodations are obtainable it might result in the House of Delegates'

decision to accept an invitation to hold our 1921 meeting in Ann Arbor.

To return to our subject—we extend our good wishes for the success of these clinical meetings and urge attendance at them. They will certainly accomplish much for the good of all.

JUST A THOUGHT.

Read this thought, ponder over it; then, if you will, execute it.

This is your Journal and you are assumed to be not alone a reader but also an editorial collaborator and supporter. The publication of the Journal is not a single individual's or a small group of individual's responsibility. Primarily the Journal belongs to and is intended to be representative of the entire profession of Michigan. It is your official organ and reveals your individual as well as collective status, ability and progressiveness. It reflects the professional attainments, alertness and abreastness of the entire profession of this state. It establishes, in a great measure, our professional standing among medical men in this country. It creates the final appraisal of the value of our state organization.

If you concede all of this to be true, then you have as an individual a definite obligation to your Journal. That obligation consists of (a) Submission of Original Articles and Clinical Case Reports that are scientific, practical and of timely value. (b) Submission of Constructive Comment and also criticism upon professional and organizational activity in our state. (c) The sending in of news notes and items and reports of county meetings and hospital activities. (d) Patronage of our advertisers who aid in defraying publication expense.

Are you willing to meet up to your obligation?

COMPULSORY HEALTH INSURANCE.

What is the attitude of the American Medical Association?

As in previous issues we have indicated that

the above movement demands study and action on the part of our members. Our committee on Civic and Industrial Relationship is aggressively active in securing information upon the subject for your benefit. It is proposed to disseminate this information through the Journal and by other means. The committee proposes to acquaint each member with the details and to outline a definite course of action.

The statement given below by the chairman of our committee, Dr. Frothingham, develops a startling as well as threatening stand of our council on Public Education of the A. M. A., the President of the A. M. A. and a certain Dr. Rubinow—the latter in a dual role of Representative of the A. M. A. and *paid employee* of the American League of Labor Legislation. (This League is not the American Federation of Labor.)

Here are some of the existing facts regarding this important subject:

This is not an argument for or against Compulsory Medical Insurance. That question is being studied and will be reported on later. This is simply a statement of facts regarding existing conditions which seem to call for action on the part of the Michigan Medical Society.

1. All the agitation, all the framing of bills and their introduction into the various State legislatures have been prepared under the auspices of the American Association for Labor Legislation with headquarters in New York City. The secretary is John B. Andrews and the letter heads bear the names of Alexander Lambert, I. M. Rubinow, Andrew Fusereth of the Seaman's union, John Mitchell, labor leader, Royal Meeker, labor Commissioner, Washington; Jane Addams, Sam A. Lewisohn and a sprinkling of more or less well-known people in social work and politics.

2. This Labor Legislation Association has had its bill for compulsory insurance introduced in nine states to date—New York, New Jersey, Massachusetts, Connecticut, Pennsylvania, Ohio, Illinois, Wisconsin and California.

3. Commissions were appointed in eight states to study and report on the measure. The first Massachusetts commission reported in fav-

or of the plan. A second commission reported against it and several attempts by the advocates to incorporate provisions for Compulsory Insurance in the new Constitution have failed. Wisconsin and Connecticut reported flatly against it. New Jersey and Ohio reported in favor. Illinois and Pennsylvania asked for more time for consideration. Later Illinois reported against.

4. Two commissions with Dr. Rubinow as paid expert counsel reported in favor of the Social Insurance in California. Dr. Rubinow conducted an active campaign in its favor but when it was put to a referendum vote, the people of California voted it down almost three to one. There were 358,324 votes against and only 133,858 in favor.

5. New York has been fighting for three years. In a letter to me, dated Nov. 20, 1919, John B. Andrews, secretary of the American Association for Labor Legislation wrote:

"Under separate cover, I am sending you a copy of the health insurance bill as it passed the Senate of New York last April. It failed to pass the House due to the autocratic action of the speaker who held the bill in committee."

6. In 1917, the American Medical Association took the stand that it would be neutral on this question and advise its study by State commissions. In 1920 the American Medical Association is still assuming to be neutral and is advising us to be neutral.

7. While we are advised to be neutral, the President of the American Medical Association and Dr. Rubinow, who had been chairman of the national investigating committee for the A. M. A., are fighting in the open, shoulder to shoulder with this American Association for Labor Legislation and thereby carrying the impression that the great American Medical Association is behind the scheme.

8. The President of the A. M. A. and Dr. Rubinow have taken this position in the face of the fact that according to Dr. Green, Secretary of the Council on Public Instruction, an overwhelming majority of the medical profession have been against the plan, in the majority of states in which Compulsory Insurance

has been discussed. Dr. Green wrote me under date of Nov. 20, 1919:

"Unfortunately in the majority of states in which this question has come up for discussion, the medical profession has been divided into two camps; the first a small group, influenced by the attitude of theoretical sociologists in favor of the plan and an overwhelming majority who were violently opposed to the proposition without investigation, because they feared it would interfere with their business."

9. We must assume that the medical profession of New York are men of at least ordinary brains and intelligence and if after three years of fighting and propaganda, they are still opposed to the measure, it would seem that the purpose of further delay for investigation was not prompted by a desire to educate but in a determined effort to tire out the opponents of Social Insurance. Particularly, when you consider the attitude of Dr. Lambert, president of the A. M. A. His association is pledged to neutrality but as president he does not seem to be bound by the laws of the Association.

10. New York is entering on its fourth year of fighting this measure. These men believe that the proposed Compulsory Insurance is a menace not only to the worker, himself, but to the taxpayer and citizen and that it means the death blow to the practice of medicine. What support are they receiving from the Association and its official Journal? The Journal says that New York will be a good state in which to make a test and nothing more.

11. The Schenectady County Medical Society of New York has raised the issue squarely. They ask the aid of Michigan in finding out whom the officers of the A. M. A. represent. Is it the men who elected them to their offices or do they represent the American Association of Labor? Shall an Association be pledged to neutrality and its officers and Journal permitted to send out propaganda in favor of a measure which is being bitterly fought in many states?

12. "The strength of the wolf is the pack and the strength of the pack is the wolf." At best, this question of Compulsory Medical Insurance is of very questionable value to the American citizen, be he laborer, professional

man or ordinary citizen. It has worked out badly in many places where it was tried. In one country there were 1100 strikes of physicians; but be its merits or demerits what they may be, can we afford to let an Association and a Journal which has been built up by the efforts and money of the Medical fraternity be turned over to any association whether it be labor legislation or any one else without the consent of its members. This is what is being done to-day by the president of the A. M. A. and the propaganda sent out by the American Medical Journal.

13. To remain neutral, while the opposition smashes down defenses and builds in-trenchments does not seem a very wise policy.

EXPLOITATION THERAPY.

In view of an editorial which appeared recently in the Weekly Bulletin of the Wayne County Medical Society, in which the statement is made, that due to the advanced newspaper notices and comments involving a claimed newly discovered chemical cure for cancer, and which cure had received serious official consideration from the society, through the appointment of a committee of investigation, such advanced press notices resulting in the author of the cure being overwhelmed with patients from all sections of the country, and to such an extent that it was an impossibility for him to properly demonstrate the success or non-success of the treatment to the long-suffering, but still receptive committee, it suggests itself to the Journal, that, in the future, not only in the interests of the profession, but also as a matter of safety to the public, in any consideration given officially to claimed discoveries or cures some restrictive and non-advertising method should be devised by which the inventor or author should be firmly held in a legal agreement that, excepting through legitimate research practice controlled by a committee, patients should not be treated or fees received by the author until such a time as the committee's report had been received and acted upon.

Until a method of treatment, or a claimed

curative agent, has been properly and conclusively passed upon by competent and recognized investigators, it would seem proper that the material rewards in connection therewith should be withheld until such a time as they could be esthetically received, and without violation of at least the spirit of section 3, clause 6, of the Medical Act, relating to "grossly unprofessional and dishonest conduct, which is declared to mean, (b) The obtaining of any fee on the assurance that an incurable disease can be permanently cured. The mere fact that no guarantee of cure is given does not change or modify the legal interpretation of the word "assurance." "Acts speak louder than words" is especially emphasized in court procedure. Certainly the "laborer is worthy of his hire," but in the history of ninety-nine of all heralded cures, the fee shortly precedes the death certificate.

It has been suggested, "Why the Rockefeller Research Bureau?"

In commenting upon the so-called cure, it is to be understood that in the absence of evidence, pro or con, no opinion is ventured as covering its merits. It is to be sincerely hoped that some effective remedy for CANCER has been discovered, in spite of the methods involved in its proof.

Editorial Comments

Our good friend, the Editor of the Indiana State Medical Journal, (and likewise the son of our own Dr. Bulson), ably comments upon the unnecessary removal of tonsils and teeth in our zest to obliterate all sources of possible local infection. The warning note sounded, while not new, is timely and to the point. Many tonsils have been removed, many teeth extracted without justification. Likewise in many of these cases the work has been so unskillful and incomplete that the patient is much the worse for it. Tonsillectomy and adenoidectomy is not a simple operative undertaking. It requires more than ordinary skill and a tonsillectomy to properly perform it so as to prevent leaving tags, stumps, damaged pillars and post-nasal trauma. Their removal should be recommended only for thera-

peutic reasons that have been clearly demonstrated by careful clinical study, and not primarily for a mercenary reason, which we fear has all too frequently inspired recommendation for the surgical attack. We join you in supporting those who utter timely warning against the ruthless removal of tonsils and teeth.

The 1920 Annual Meeting of the American Medical Association will be held in New Orleans during the week of April 26th. The faculty of the Tulane University join with the profession of New Orleans in assuming to arrange for a successful meeting and a good attendance. Are you planning to go?

The Grace Hospital Bulletin, Detroit, that suspended publication for a year on account of the war has again put in appearance. Seven excellent articles contributed by members of the Hospital Staff comprises this last issue of volume three. Those desiring to receive copies should write to the Superintendent of the Hospital.

We ask all our members to become acquainted with their senators and representatives. Learn to know them and go out of your way to do so. Later on in the year you are going to be asked to have a confidential talk with them. Just now we desire most that you cultivate their acquaintance.

According to our best available reports there remain not quite four hundred eligible physicians in this State who are not officiated with our Counties and State Society. We purpose, if possible, to secure their applications this year. To accomplish this we call upon every county society and member to take such steps as will bring about their applying for membership. Go out after your associate, neighbor and fellow and tell him why he should join and invite him to your next meeting and so clinch your argument. If we all join to bring about this membership campaign it will be easy, short and sweet. Why not start today to round up the men in your county? Let's clean up the job in short order and wipe out our having to record 400 eligible non-members.

Every member should receive a copy of each number of the Journal. If you are not getting it the reason is you haven't sent in your change of address. We find in every instance where a complaint of non receipt of the Journal is made

that we were never informed of the change of address. The postal authorities do not forward second class mail matter and nowadays local postoffices are not keen to make deliveries where removals have occurred from one carrier's territory to that of another carrier. If you are not receiving the Journal send us your correct address. County Secretaries are requested to repeat this announcement to the members of their society.

Every once in awhile the query reaches us, "Now that 'Dakin's solution' has ceased to be a novelty and hobby what's next?" Who will make the guess. Interstitial Glands, Radium (that's pretty expensive). A pneumonia serum (sure to abort this time), a cancer cure—we give up for there is no telling what and where the new idea will be or appear. As to Dakin's we still hold that if more care was given to the first operative attention of the wound or injury there would be but little call for after "flushings" and dressings. There is no denying that infection may be reduced to a minimum per cent. if the right kind of care is given when the injury receives your attention the first time. An infection in a wound, seen by a doctor shortly after it has been sustained—one or two hours, is indicative of superficial and lack of thorough treatment and first dressing. The large majority, if not all, can be prevented by the right kind of care and treatment.

In this agitation against the Reds and the need of Americanization of our foreign population we must not be unmindful of the younger generation of children of this class of people. The principles of Americanism must be inculcated during their public school training. And incidently, for the good of all children, it would beget a better coming generation if we would clear out from our public school teaching staffs all the curly-headed, wizened faced, soured, bespectacled old maids and matrons and replace them with young men. This, in order that our boys and girls may come in contact with virile American manhood and be the better men and women for it. Then, pay our teachers a living wage. There is need for a general shaking up of many of our schools and school boards.

"Yale Surgery Chair For Sale—Enquire * * *." This is a notice that was observed upon a certain Bulletin Board. We are wondering if the purchaser has the professorship conferred upon him?

From time to time criticism is directed against the efficacy of Roentgen Ray therapy in malignant disease. Most authorities agree that it is beneficial and should be employed in conjunction with the surgical procedure, especially following operative work. It is conceded, however, that it is not always productive of the same beneficial results. The explanation may lie in the fact that all the exposures, their time and frequency have not been uniform. Then too there has been a fear of a burn. To us it has always seemed that our Roentgenologists have been obsessed by this fear of a burn, especially when treating carcinomas of the mammary gland pre and post operatively. The intensity, length and frequency of exposure has been consequently limited to that extent—not to produce a burn. It seems to us that in supporting such a practice we are inconsistent. We recommend and achieve the bold sacrifice of involved structures and wide areas of surrounding fascia, muscles, lymphatics, vessels and if need be nerves. Then we draw up short and decry this additional agency for fear of the results of a X-ray burn. Many a thorough and splendid piece of surgery is limited in its end result because of failure to employ intensive X-ray therapy because a burn might result.

We incline to the practice of prolonged, intensive and frequent X-ray exposure following malignant or border line cases where surgical measures have been employed to remove the neoplasm and adjacent permeated areas. Let's have the burn, with all its annoyance and dressings if a reduction of mortality from malignant disease be attained. For this we should support our Roentgenologists and encourage them in overcoming the fear of burns—all of course providing it is demonstrated that effective dosage cannot otherwise be obtained. We are fully familiar with the difficulty encountered in treating these burns—they are, however, a lesser evil.

Will not our Roentgenologists rise up and discuss this feature of X-ray therapy. Our pages are at their disposal.

We have had considerable discussion regarding experiences of army surgeons with empyema cases that came under their care in Base Hospitals. We would welcome reports of their experiences that they are again encountering with cases of empyema arising in their civilian practice. Then may we have a comparison of pre-war, war and post-war results. The military experience—thoracotomy, Dakin's solution and a few other so-called, new-fangled procedures—have not established the final method for dealing

with empyema. Let the discussion be carried on until we reach a unity of opinion, if such be possible. Eighth and ninth rib resection posteriorly, two drainage tubes, posture, no irrigation, "Two bottle blowing lung exercise," may yet be the common ground upon which a majority will agree as being the most effective, efficient practice—Dakin's enthusiasts to the contrary.

We publish in each issue the advertising announcements of several reliable laboratories located in different parts of our state and in Chicago. They are so located as to be of easy access to the entire profession of the state. Individual doctors cannot be expected to equip themselves with the laboratory paraphernalia requisite for reliable, chemical, bacteriological, pathological and sero examinations—neither have they the time to perform these laboratory examinations. Such laboratory aid is requisite in reaching a proper diagnosis in a large number of instances. Therefor we urge that you patronize these advertisers in your Journal who are trained specialists and upon whose reports you may rely. You will find them all prompt, willing and ready to cooperate with you on all occasions. Give these advertisers your preference when sending out your specimens.

There may be something to this "Ground Hog Seeing His Shadow" myth regarding the weather. What we are in earnest about is that every doctor in Michigan shall see his own shadow and take an inventory of his present and future surroundings and prospects. We don't believe a single one wishes to see his shadow become so small that as an individual he becomes nothing more than a hireling and a "bureau employee." We urge that you now become vitally interested in the question of Public Health Insurance and counteract the propaganda that is being passed out by idealistic individuals. Your future rests upon the defeat of their program.

February may be a short month but your society has two meetings, possibly four, which you should not fail to attend.

County Secretaries when remitting State dues are requested to take particular pains to give accurate addresses of members. There have been many changes in location and removal to new offices. Unless we have the proper address we cannot assure delivery of the Journal. Please

aid us in correcting our mailing list by noting each member's present address.

A nurse, trained, receives \$25.00 to \$35.00 per week of 20 hour days. A girl in a brush, brass or other factory, untrained, receives from \$18.00 to \$33.00 per week of five and a half days of eight hours. The trained nurse works 140 hours per week, the girl in the factory works 44 hours per week. One spends three years in training, the other three weeks. Which one is underpaid? Which one is entitled to more pay? Do you wonder why more girls do not enter our hospital training schools or why it is so hard to secure trained nurses for private cases?

A goodly number of our local societies are holding splendid meetings with live programs. This is a very encouraging feature of organizational work for it arouses interest and inspires attendance. Michigan needs the interest and support of its doctors in Society work to maintain professional advancement and to secure recognition of professional rights. The work of obtaining cooperation rests with county officers and to these officers should go the credit for the end results and the benefits that ensue.

Attention is directed to our advertising section. Please note the new ads and also those of our old advertisers. Each one merits your patronage in preference to any other firm. Your cooperation is solicited in securing additional contracts and also to hold our present contracts and make advertising in the Journal valuable to all who purchase space.

Once again, your 1920 dues are payable. Please comply by prompt remittance to your County Secretary.

The indication and need of increased fees for professional services in these days of soaring cost of everything is imperative. It costs more to have a plumber come to a home to fix a faucet than for a Doctor's visit to attend a child with pneumonia. Which is the more skilled laborer? How long do you propose playing second to the plumber?

There is no law, movement or cult that will make an old plug equal to the thoroughbred, put them both side by side, on equal basis and cause them to go down the home stretch neck and neck. Think it over and see if the same thought does not apply to the human race in our propa-

ganda movements for labor equalization, socialism and a world safe for Democracy. In the present times when there exists such a mental and moral hunger for a plan or way out of the chaos that exists we need less of commissions, less legislation, less conferences. We do need more work, longer working hours, greater enforcement of laws, and a reverting back to the provisions of the Constitution upon which this Republic was founded. Autocracy begets tyranny. Democracy begets "mobism" and mob rule. A Republic is the safe and happy medium.

Elsewhere in this issue will be found the Minutes of the Midwinter Meeting of The Council. We urge that you read these minutes carefully and thus become informed as to the work of your state organization.

Dear Sir:

I am now writing to you for to see If you will Please send me A certificate for Practing medicine I have Practis for thirty-five years and i did also have a certificate till my House Burent and also my certificate Burent also and i Received my certificate from Doctor ----- and i did not Have it Recorded and the doctor I got my certificate from is dead and i do want to get another one from the United States, i do Want to RePly from the United States for all I can. and i do Doctor cronic Dezeses and i Doctor the Blood, Stomach, also i doctor the Nerves liver and i am a Stashneary doctor I doctor With Roats oils and Herbs and if you wish to know of my practice why you Can here from Mr. -----'s Drug Store at ----- Dr.-----

The above letter reveals we are not all surgeons.

Suppose the members of the American Medical Association should hold a convention at which they adopted a resolution demanding an increase of 60 per cent. in fees, a six-hour day, a 30-hour week, extra fees for overtime, and bound themselves to refuse to perform any service whatever for the public until these demands were complied with. Imagine the plight of the sick and injured, and measure if you can the state of public sentiment toward the American Medical Association.

Suppose the Retail Grocers' association should adopt a resolution binding the members not to sell an ounce of food to members of the American Medical Association or to anyone connected with them while the unreasonable demands

stood, basing their action on the ground, among others, that the attitude of the doctors menaced the life, health and comfort of the nation in general and the prosperity of the grocery trade in particular. Imagine the plight of the doctors' families, their wives and little children.

Suppose the farmers of the United States in convention assembled demanded an eight-hour day or less, thereby curtailing food production, and a price for their product which would raise the average pay of farmers to that of any day laborer, and suppose the farmers refused to sell a bushel of grain or a pound of fruit or vegetables until their demands were satisfied. What would happen to the city office workers, the flat dwellers and the myriads of men in mine, mill and factory?

Before the worst in the way of alimenation happened, civil chaos would ensue, anarchy would prevail, every man's back would be to the wall and survival would depend upon brute force. No man liveth unto himself. No man, however rich or poverty-stricken, but is dependent upon the service of his fellow men.

Flint, Mich., Journal, Dec. 20, 1919.

Correspondence

University Hospital, Ann Arbor, Mich.

CLINICS FOR PRACTITIONERS.

The Staff of the University Hospital announces a series of medical, surgical and special clinics to be given on the afternoon and evening of the second Wednesday of every month and the morning of the following day.

These clinics are intended to help practitioners to keep abreast of new and interesting developments. Difficult cases will be demonstrated and discussed. An added feature will be a clinical-pathological conference on cases coming to necropsy.

The plan has been arranged to enable practitioners to see the maximum amount of clinical material with the least expenditure of time and to carry out the policy of the Hospital to put its teaching facilities at the service of the profession.

Conferences will be held in the surgical amphitheater of the University Hospital unless otherwise stated. The schedule has been arranged with the view of allowing practitioners to

make the best train connections in reaching and leaving Ann Arbor.

The exercises will start at 1:30 p. m., 7:30 p. m. and 8.30 a. m. The first conference will be held January 14th and 15th, 1920.

Christopher G. Parnall, M. D.

Director of the Hospital.

Chicago, December 24, 1919.

Dr. F. C. Warnshuis,
Grand Rapids, Mich.

Dear Doctor Warnshuis:

Thank you for your letter of the 22d inst., and for your offer. The problem of securing medical news from all except the very large cities is a very old one, and one which I have long ago given up all hope of solving. Everey now and then we receive a criticism because we apparently are ignoring some particular city, or cities. In such cases we write to the critic asking for advice as to how we can get news, if he will be good enough to assume the task of sending it, etc., etc., etc. So far as Michigan is concerned, we have had correspondence with different men; they have promised to send items, and that is where it has ended. The fact is, for weeks at a time there may be no news worth reporting, and the individual who is supposed to represent the Journal and to be on the lookout falls asleep on the job, and when something happens he forgets all about sending it.

Except in the very large cities, where there is something happening—and these can be counted on the fingers of one hand—the only thing we can do is to depend on the clipping bureaus. We have five or six of these, and they cover the central states—especially Michigan—very well, at least we had thought so. There are, of course, some items of medical interest that would not be of interest to the public, which do not get into the newspapers. If only we had someone to report these when they occur, it would be ideal. Again thanking you for your letter, and with the season's greetings, I am

Sincerely yours,

George H. Simmons, Editor,
Journal of the A. M. A.
Alpena, Jan. 2, 1920.

To The Editor:

I am very much interested in the proposal of the State Society to give a sort of post graduate school of instruction in various centers. Alpena

wants to be in on this. I would suggest that a half-dozen of the best available men covering the different branches of medical science be arranged in a sort of Chautauqua tour and that they visit the various cities suggested, including Alpena, either for a week in June, or else that they come monthly. Nothing would add interest to the smaller societies as much as real instruction at regular meetings. The societies desiring to enter the scheme might show their interest by contributing \$100 towards the expense. The balance to be made up by the State Society.

The Alpena Medical Society is looking forward to a profitable year. Our new President, Dr. Geo. Lester, of Hillman, says we are to go over the top with a 100% membership; if so, you may expect another check soon for nine more members.

Truly yours,
C. M. Williams, Sec'y-Treas.

Jan. 12, 1920.

Editor M. S. M. S.,
Grand Rapids, Mich.
Dear Doctor:

In regard to your editorial article in the last number of our State Journal suggesting that the county societies should hold regular and frequent meetings. Does it occur to you that in some of the counties that such a thing is impossible after the roads are snow bound and with such poor train service?

In this, Benzie County, it is impossible to use our cars after the snow gets deep on account of the "high track" difficulties caused by the universal use of sleighs of narrow gauge.

If our State legislature would make it mandatory that all vehicles should be of a standard width of track it would allow cars to be used much later in the fall and much earlier in the spring and sometimes all winter long. Under the present system country doctors cannot render the service that the sick frequently need on account of impractical roads.

And further there is no point where we can all meet and return the same day by traveling on the railways as some of the roads do not even have daily service in the winter months

Respectfully,

E. J. C. Ellis.

Reply: We are not unaware of the existence of such obstacles in certain parts of our state. When the elements raise such obstacles and

State solons will not supply a remedy, of course, these societies are up against it. We urge, however, to go the limit in every county and hold as many and frequent meetings as possible. We appreciate the difficulties that exist.—Editor.

Deaths

Sir William Osler.

Sir William Osler died, December 29, 1919, at his home, Nordham Gardens, Oxford, England. He suffered an attack of pneumonia ('The Old Peoples' Friend') in October. This was followed by empyema and death. He was born at Bond Head, Tecumseh, Ontario, July 12, 1849. He studied at Trinity College, The Toronto School of Medicine and graduated from McGill University in 1872. He continued his studies in London, Berlin and Vienna. He was appointed Professor of Physiology and Pathology in McGill University. In 1884 he accepted the Chair of Clinical Medicine in the University of Penn. The following year he was chosen Galstonian Lecturer in the Royal College of Physicians in London, England. In 1886 he was Cartwright Lecturer in the College of Physicians and Surgeons, New York. In 1889 he became Professor of the Principles and Practice of Medicine in Johns Hopkins University. In 1904 he became Regius Professor of Medicine in Oxford University, Oxford, England. He was a F. R. S.

Doctor Osler was interested in everything pertaining to medical history and he was the possessor of a library of rare medical works. He wrote Osler's Theory and Practice of Medicine which has run into nine editions. He was also the chief editor of an elaborate system of medicine comprising a number of volumes. He was a prolific writer on medical subjects as well as philosophical ones.

Sir William Osler was magnetic and witty; and the possessor of a remarkable faculty for remembering names and faces. He was loved by his associates and by his students. He was a scholar, a great teacher and a wonderful clinician.

Doctor William M'Carroll died at his home in Pontiac, Michigan, December 12th, after an illness of several months.

Doctor M'Carroll was sixty-five years of age and was one of the best known older physicians of Pontiac. He was a graduate of the class of 1881 of the University of Michigan after which he returned to Pontiac where he remained in active practice up to about a year ago when his health began to fail.

State News Notes

COLLECTIONS.

Physicians' Bills and Hospital Accounts collected anywhere in Michigan. H. C. VanAken, Lawyer, 309 Post Building, Battle Creek, Michigan. Reference any Bank in Battle Creek.

FOR SALE—General Practice in best town north of Grand Rapids; One Thousand Population; Good Churches and Schools; High School on approved list; Good Roads; splendid farming country. My collections were over \$7,000.00 last year. Books open to inspection; opposition nil; nearest competition twelve miles distant. Any good man can do between \$5,000.00 and \$6,000.00 first year. District remarkably free from Hay Fever. Good hunting and fishing within one hour or less by auto. Also good perfectly modern 10 room house; good garage and barn, new, good office up town. All will be sold for about half the cost of house. Reason for selling: Owner wishes to Specialize. Address "Journal 104."

For many years it was comparatively easy for the laity to purchase narcotics. This produced many habitues of opium and its alkaloids and likewise cocaine. Very drastic legislation became necessary to curb this evil. One result of this is that physicians, who have always been very scrupulous in their use of narcotics, often find it quite inconvenient to prescribe what they regard as legitimate and entirely necessary amounts of narcotic drugs, particularly opiates.

Physicians, however, are coming to realize that opiates are more or less dispensable in many conditions where they have heretofore been considered necessary. They have been casting about for the most suitable substitutes that could be prescribed without restriction by law, that would not tend to habit formation.

In this connection it is gratifying to note the co-operation offered by Eli Lilly & Company in the way of a vest pocket reference entitled "Standard Anodynes, Sedatives and Hypnotics." In this edition there are more than ninety items mentioned which are non-narcotic, but which may be employed for anodyne, sedative or hypnotic effects. Others are listed which contain small amounts of opiates, but require a federal record of sale only. This booklet should prove very helpful to physicians generally, since it not only mentions products, but gives brief descrip-

tions of therapeutic application and dosage.

Physicians will profit by requesting copies of this booklet from Eli Lilly & Company, Indianapolis.

DETROIT BOARD OF HEALTH—CLINICS.

Veneral Division—

Station 1—33 Mullett St.

Tuberculosis Division—

Station 1—33 Mullett St.

Station 2—578 Wessen Ave.

Station 3—1257 Dubois St.

Station 4—36 Peterson St.

Station 5—529 Davison Ave.

Child Welfare Division—

Station 1—33 Mullett St.

Station 2—578 Wessen Ave.

Station 3—1257 Dubois St.

Station 4—36 Peterson St.

Station 5—529 Davison Ave.

Station 6—2313 Michigan Ave.

Eye, Ear, Nose and Throat Division—

Station 1—33 Mullett St.

School Dental Division—

Bishop School.

Children's Aid—33 West Warren Ave.

Children's Free Hospital—Brush & Farnsworth Sts.

Department of Health—33 St. Antoine St.

Detention Home—Hancock & Rivard Sts.

Ellis School.

Greusel School.

Garfield School.

Grace Hospital—John R & Willis Sts.

Harper Hospital—John R & Martin Pl.

House of Good Shepherd—Fort St. West.

Harms School.

Nellie Leland School.

Russell School.

John D. Rockefeller has recently given away \$1,000,000. Half of it goes to the Rockefeller Foundation and half to the General Education Board, also a Rockefeller institution. The major function of the Rockefeller Foundation has been to promote health. Its comprehensive activity is reflected first by the Rockefeller Institute for Medical Research. Then, in twelve States and indeed in fifteen countries, the Foundation has been battling the hookworm disease. Its experiments in controlling malaria through co-operation with the Public Health Societies

has brought convincing results. So have the experiments in the after care of infantile paralysis cases. The foundation is also campaigning against tuberculosis in France and against yellow fever in Ecuador. It has built a large and thoroughly equipped medical college at Pekin and is beginning another at Shanghai. It grants about a hundred fellowships to foreign scholars who are pursuing courses in American medical centers. It contributed during the war some \$22,000,000 to war work agencies.

The Foundation's work is sometimes confused with that of the Carnegie Institution, founded to encourage general investigation, research, and discovery. The Carnegie Institution works specifically for the promotion of science while the Rockefeller Foundation is a fund by which Mr. Rockefeller has organized his benevolence.

As the first half of Mr. Rockefeller's latest gift will be used to combat disease, so the second half will be used to increase teachers' salaries. The donor will help them both body and soul.

The General Education Board has been aiding American institutions of learning by making contributions to their endowments conditional upon the raising of additional supplementary sums by the institutions thus favored. But this particular gift to it is to go for a very definite object. In these times of enormously augmented cost of living nothing is more evident than that salaries in the teaching profession must be increased if men and women are to remain in that profession and if younger men and women are to be induced to enter it. Mr. Rockefeller's provision to this end reads as follows:

"I should cordially indorse a decision to use the principal as well as the income as promptly and largely as may seem wise for the purpose of co-operating with the higher institutions of learning in raising sums specifically devoted to the increase of teachers' salaries."

As with the Rockefeller Foundation and the Carnegie Institution, so the work of the General Education Board and the Carnegie Foundation for the Advancement of Teaching are sometimes confounded. The latter institution has two distinctive functions, educational inquiry and payment of retiring allowances to college professors and of pensions to their widows. (The Outlook, Jan. 7, 1920.)

The members of the St. Clair County Medical Society by concerted action have increased their fees as the following announcement indicates:

St. Clair County Medical Society.

STATEMENT BY PHYSICIANS OF THE CITY

For the past three years, while the cost of all materials has advanced in an alarming degree no class of merchandise has reached the high prices attained by medical and surgical supplies. And again the industrial growth and natural development of our city has caused large increases in office rents. Through all this period the physicians of the city have maintained their old schedule of fees feeling that prices would return to normal after the war. Since the close of the war the cost of things in general and especially prices pertaining to the upkeep and maintenance of a physician's equipment have steadily advanced. An analysis of the situation shows that the physician's overhead expense has increased over 200 per cent. in the essentials. For this reason it has been found necessary to readjust the schedules of fees so that after Jan. 1, 1920, the physicians of this city will maintain the following charges:

Day calls	-----7 A.M. to 6 P.M.	-----\$3.00
Evening calls	---6 P.M. to 9 P.M.	-----\$4.00
Night calls	-----9 P.M. to 7 A.M.	-----\$5.00
Office consultations	-----	-----\$2.00

As most physicians utilize the forenoons for making their rounds, patients are requested to send in their calls early in the day so that the doctor may better systematize his plans thus facilitating his work and also allowing him more time to spend in his home. To be most efficient physician needs proper rest and recreation. If the public will co-operate in this respect by calling the doctor early in the day when possible, it will allow him to render more prompt and effectual service. In many instances calls that could have been sent in during the daytime are postponed until evening or late at night.

In real emergencies, however, the physicians will gladly extend as prompt service as possible whatever the hour.

The Wayne County Medical Society proposes to erect a bronze tablet in honor of its members who served in the recent war; and, that the Patriotic Committee, who has the matter in hand, may be sure to have a correct list of all members who were in service, will such members write the office of the Society—33 East High St., Detroit—to the effect they were in service, Army or Navy, length of time, rank, and whether overseas.

AMERICAN CONGRESS ON INTERNAL MEDICINE.

This organization, in conjunction with the American College of Physicians, meets at Chicago, February 23 to 28, 1920

The Sessions will comprise daily clinical and laboratory demonstrations in many of Chicago's leading hospitals and teaching institutions. There will be several evening gatherings. These will

be addressed by men eminent in American Medicine. One of the evening meetings will embrace the Fourth Annual Convocation of the American College of Physicians.

Hotel accommodations must be spoken for at once. Detailed information with regards headquarters, hotels, clinics, scientific demonstrations, etc., may be secured by addressing Dr. Frank Smithies, Secretary-General, 1002 North Dearborn St., Chicago, Illinois.

Dr. C. B. Gauss has located in Lansing.

Dr. Arthur M. Hume is devoting his whole time as inspector for the U. S. Public Health Service work among ex-soldiers. His splendid

organizational work has resulted in establishing an acting assistant surgeon or examiner in every county of the State.

Ethical Physicians of the United States and Canada who are interested in the advancement of what is best in clinical and scientific medicine and its affiliated sciences are cordially invited to attend all sessions of the American Congress on Internal Medicine. The gatherings will be of great practical and scientific worth.

Dr. Frank Suggs has returned from service and re-located in Highland Park.

Dr. A. C. Huebner of Bellaire has located in Ithaca.

COUNTY SOCIETY NEWS

It is the Editor's desire to have this department of the Journal contain the report of every meeting that is held by a Local Society. Secretaries are urged to send in these reports promptly

ALPENA COUNTY

The regular meeting of the Alpena Medical Society was held Thursday, Dec. 18, in the parlors of the Alpena House. Drs. Dunlop, Secrist, McKnight, McDaniels, Bertram, and Williams were present. The following officers were elected for the year 1920:

President—Geo. Lister, Hillman.

Vice-President—Samuel Bell, Alpena.

Secretary-Treasurer—C. M. Williams, Alpena.

Medico-Legal—W. A. Secrist, Alpena.

Delegate—D. A. Cameron, Alpena.

Alternate—Wm. Arscott, Rogers City.

We note that the State Society is planning on a sort of a University extension course for doctors. Alpena wants to be in on any such forward looking program, and invites the State Society to remember us in the selection of the centers. We have a good Hospital and will treat our visitors right.

C. M. Williams, Secretary.

GENESEE COUNTY

The Genesee County Medical Society met for noon luncheon at the Dryden Cafe Dec. 3, 1919, President Randall in the chair. Dr. Lafon Jones, of Flint, gave an interesting talk on "Acute Infectious Jaundice." He discussed the Epidemiology of the disease during its recent occurrence

in Flint and reviewed the newer theories of its Etiology and Pathology. Dr. F. C. Kidner of Detroit read a paper on "Peripheral Nerve Injuries and their Treatment." This was based on an extensive military experience and covered the subject in all its details. Rev. Fr. Patrick Duni-gan, of Flint, late Chaplain with the Over-seas Forces, was introduced and paid an eloquent tribute to the Medical Profession. He also reminded us of our responsibilities to our patients and to the community, begged us not to lose faith in our fellow man, and asked us to spread the doctrine of Good Cheer.

The Society again met on Wed., Jan. 7, 1920. Dr. C. B. Burr of Flint spoke on "The Value of Membership in the Medical Society." Drawing apt lessons from the recent war and from the industrial world, he showed the necessity for our profession to become better organized. This organization should be for our mutual benefit and should not be a detriment to the public. He stated that while everyone is actuated by self interest, yet it is expedient to be decent and to give the square deal.

Dr. C. H. Baker, Pres. of the State Society, briefly told us what the State Society was doing and outlined some of the plans for future activity. On account of pressure from the outside, it would be necessary for us to give our immediate attention to the subject of Compulsory

Health Insurance. He then read a paper on "The Principles of Cosmetic Surgery of the Face." This was well illustrated by lantern slides. The paper was discussed by Drs. Bird, Ballard and Bahlman.

The Genessee County Medical Society met on Wed. Dec. 17, 1919, Pres. Randall in the chair. Dr. J. G. R. Manwaring spoke on "The Future of Hurley Hospital." He presented figures which showed that the number of beds available in Flint was much below the average of cities of our size and estimated that we must have at least 500 additional beds within the next five years. He urged a proper standardization of hospital methods and showed the need of keeping proper case histories. He believed that all laboratory examinations should be free. He presented a most excellent plan for starting the training of nurses in the vocational department of the high schools.

Dr. Allison of Detroit, formerly resident physician of Saranac Lake Sanatorium, N. Y., and late Roentgenologist of Col. Blake's Hospital, Paris, France, was introduced and read a paper illustrated by lantern slides on "Types of Clinical Tuberculosis and the Differential Diagnosis from Diseases with which they might be confused." He urged a better correlation of the findings of the Clinician and the Roentgenologist and also the adoption of a better nomenclature. He demonstrated very clearly the dependable features of an X-Ray plate of the chest.

W. H. Marshall, Secretary.

GRAND TRAVERSE-LELANAU COUNTY.

At a meeting of the Grand Traverse-Leelanau County Medical Society held December 2, 1919, the following officers were elected for the ensuing year. President, Dr. J. W. Gauntlett, Traverse City; Vice-President, Dr. H. B. Kyselka, Traverse City; Sec.-Treasurer, Dr. H. V. Hendricks, Traverse City. Member of Medico-Legal Committee, Dr. J. B. Martin, Traverse City. Program committee, Dr. E. B. Minor, Traverse City.

Dr. Alfred C. Wilhelm of Grawn, Mich., reported an interesting obstetrical case, and Dr. Minor presented a case of a man with a subdeltoid bursitis.

H. V. Hendricks, Sec'y-Treas.

GRATIOT-ISABELLA-CLARE COUNTY

The December meeting of the Gratiot-Isabella-Clare was held at Brainerd Hospital, Thursday Dec. 11, at 2 p. m.

President Baskerville called the meeting to order. The minutes of the previous meetings were read and approved. Communications were read and disposed of.

The applications of Dr. C. F. DuBois and Dr. A. A. McNabb were received and referred to the board of censors, upon whose recommendation they were duly elected to membership.

The report of the Secretary was read and approved.

Dr. C. F. Pankhurst of North Star then read a very interesting paper on "Tonsilectomy in the Treatment of Bronchial Asthma." The Doctor has an autogenous vaccine made, with which he treats the patients after removing the tonsils. So far he has cured 18 out of 20 patients in this way.

The paper was discussed by every one present.

The following officers were elected for 1920:

President—E. T. Lamb, Alma.

Pice-President—C. D. Pullen, Mt. Pleasant.

Secretary—E. M. Highfield, Riverdale.

INGHAM COUNTY

At the Annual Meeting of the Ingham County Medical Society the following officers were elected for 1920:

President—F. M. Huntley.

Vice-President—F. J. Drolett.

Secretary-Treasurer—Milton Shaw.

Delegates to the State Society—B. M. Davey and M. L. Holm.

Alternates—Samuel Osborne and John G. Rulison.

Representative on Medical Legal Committee of State Society—B. D. Niles.

Milton Shaw, Secretary.

KALAMAZOO ACADEMY OF MEDICINE

The annual meeting of the Kalamazoo Academy of Medicine occurred December 9, 1919.

After the routine business, election of officers took place with the following results:

President—Walter den Bleyker.

First Vice-President—W. E. Collins.

Second Vice-President—L. E. Wescott.

Third Vice-President—Malcom Smith.

Treasurer—Dan H. Eaton.

Secretary—B. A. Shepard (elected 1918 for 3 years.)

Librarian—Blanche Eppler.

Censors—W. A. Stone, A. L. Robinson.

Delegates to State Society—Drs. R. E. Balch, G. F. Young, O. D. Hudnutt.

Alternates—Drs. Della P. Pierce, C. H. McKain, J. Van Ness.

The following Scientific Program was then carried out.

1. "Some Aspects of the Examination of the Heart."

Dr. R. C. Bardeen, Madison, Wis.

2. "Renal Tuberculosis."

Dr. Hugh Cabot, Ann Arbor, Mich.

The afternoon program was followed by a banquet at the Park-American Hotel in honor of the members of the Academy who were in Government Service during the War.

There was a large attendance, both at the afternoon meeting and banquet. "One of the most interesting and profitable days" was the expression of a goodly number.

B. A. Shepard, Secretary.

MECOSTA COUNTY.

I am pleased to hand you herewith a check for \$52.50, in payment of 15 members of Mecosta County Medical Society, to the State Medical Society, whose names are on the enclosed separate sheet.

At a recent meeting of our Society, the following officers were elected for the ensuing year: Pres., B. L. Franklin, Millbrook; 1st Vice-Pres., G. H. Yeo, Big Rapids; 2nd Vice-Pres., J. B. Campbell, Stanwood; Sec. & Treas., D. MacIntyre, Big Rapids.

A new fee schedule was adopted at this meeting, which materially increased the fees along certain lines, principally of which was country mileage and obstetrics. Hereafter mileage in the country will be one mile straight. Obstetrics \$25.00, including preliminary urinalysis, and one after visit. Mileage extra if in the country. City calls \$2.00, and \$3.00 night calls. Office visits \$1.00 and upward.

It is the intention of the Society to hold frequent meetings, at which time papers on various subjects will be presented, also clinical material. It is the desire of the Secretary to create a greater interest in the meetings of the Society than has been manifested in the past, and I heartily ask your co-operation.

Donald McIntyre, Secretary.

Miscellany

FRACTURE OF THE FEMUR: THE APPLICATION OF WAR LESSONS TO CIVIL PRACTICE.

By Carleton R. Metcalf, M.D., Concord, N. H., Lieutenant, U.S.A.; *Ann. of Surg.*, Vol. LXX, Nov., 1919, No. 5.

Fractures of the femur may be arbitrarily divided into four groups: (1) Intracapsular; (2) Upper third; (3) Middle third; (4) Lower third. In these several groups we find specific deformities which must be counteracted.

1. Intracapsular—In war clinics one rarely sees impacted fracture of the hip. We have dealt with loose fractures in healthy young adults.

Deformity—Upward dislocation of the femur. In neglected lesions there has been persistent abduction of the thigh. To counteract: Thomas splint. Traction, with thigh on abduction to 35 degrees and in flexion to 30 degrees. In this position the foot naturally rotates outward slightly and should be so held. After overriding has been corrected immobilize in a plaster spica. This is analogous to Whitman's treatment for impacted fracture of the hip.

2. Upper third. a. Fracture Just Above the Small Trochanter.

Deformity—Upper fragment abducted. (Glutei pulling on great trochanter) (2) Upper fragment not flexed. (Insertion of ilio-psoas is below site of fracture.) (3) Lower fragment drawn upward, inward and slightly forward. (Composite effect of extensors, abductors and flexors on thigh.)

To counteract: Straight traction in abduction.

b. Fracture Just Below the Small Trochanter.—Common type of fracture.

Deformity—Upper fragment abducted. (Glutei pulling on great trochanter.) (2) Upper fragment flexed. (Ilio-psoas.) (3) Upper fragment rotated outward. (External rotator group—obturator, piriformis, gemelli and quadratus more than counteract anterior portions of gluteus medius and minimus, tensor fasciae femoris and ilio-femoral ligament.) (4) Lower fragment drawn upward and inward. (Composite effect of extensors, abductors and flexors of thigh.)

To counteract: Thomas splint. Traction, with thigh in flexion to 30 degrees and in abduction (about 35 degrees) until the lower fragment has been brought into alignment with the upper. Flex knee 25 degrees. Support the lower frag-

ment posteriorly to prevent subluxation. Utilize "screw pads." They are attached to longitudinal rods of the Thomas splint. If outward rotation is not overcome by the vertical pressure of the ring of the Thomas splint, it can be compensated by rotating, to a like degree, the lower fragment.

c. Oblique Fracture, Downward and Inward, Below the Small Trochanter. Deformity.—Upper fragment flexed but adducted (in distinction to the abduction of the two preceding types) by the pull of the adductor muscles inserted near the small trochanter. To counteract: Thomas splint. Traction, with thigh flexed and adducted to bring the lower fragment into alignment with the upper fragment.

3. Middle Third. Deformity.—(1) Lower fragment drawn upward. (2) Lower fragment tilted slightly backwards. (Gastrocnemius.) To counteract: Thomas splint. Traction. Correct subluxation by posterior support. Utilize "screw pads" for insistent pressure on either side of the thigh

4. Lower Third. Deformity.—(1) Lower fragment tilted backward. (Gastrocnemius.) (2) Lower fragment slightly adducted and slightly rotated outward. (Adducted magnus).

To counteract: Traction, with the knee flexed from 35 to 90 degrees. It is necessary to have firm support behind the lower fragment, especially if traction is made by some means other than calipers.

The deformities which one must guard against particularly are four in number:

1. Excessive shortening, because of inadequate traction or poor position or both. A good result entails shortening of less than one inch.

2. Subluxation of the shaft, because of inadequate posterior support.

3. Rotation of the lower fragment on the upper, with the result that a patient ultimately toes out or toes in.

4. Abduction of the upper fragment.

The Thomas splint serves as a foundation stone in several methods of treating fracture of the femur. Whichever method one employs, a few fundamental facts must be observed:

1. The size of the ring of the splint is not a vital factor, so long as it be large enough. A snugly fitting ring is preferable but not essential.

2. The posterior portion of the ring should impinge against the tuber ischii.

3. This intimate, unchanging contact can be procured only when there is a vertical pull on the ring.

4. The distal end of the splint must be elevated.

6. The Thomas splint should be bent in slight flexion at the knee—ordinarily to about 25 degrees from a straight angle. This amount of flexion is to be increased in fracture of the lower third of the femur.

7. A foot-piece may be erected to hold the foot at right angles.

8. Posterior support is had by double strips of flannel bandage running behind the limb, from one side-rod to the other.

9. Traction is procured by weight and pulley. The initial weight should be the maximum.

10. If pull and proper position do not suffice to secure alignment, employ "screw pads."

11. Leave the knee free and uncovered. Massages of the joint minimize the probability of final knee-joint disability.

12. Examine the splint daily. Adjust the flannel slings, check traction and position. Measure the length twice a week, but do not disturb the fracture needlessly. Check alignment and callus formation with X-ray pictures; a bedside machine is of great help.

13. Watch the perineum. Soap the ring before applying the splint, and soap it daily thereafter. Pearson passes between the ring and the skin a prepared strip of calico, boiled in soft soap. Rub the patient's back with alcohol.

14. Teach a patient some occupational work—knitting, basket-weaving, painting or the like—to busy him during his protracted confinement.

Leo. C. Donnelly, Detroit.

IF YOU WANT TO
DERIVE THE FULL
BENEFIT OF YOUR
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PRIVE YOURSELF
OF ITS MEETINGS.